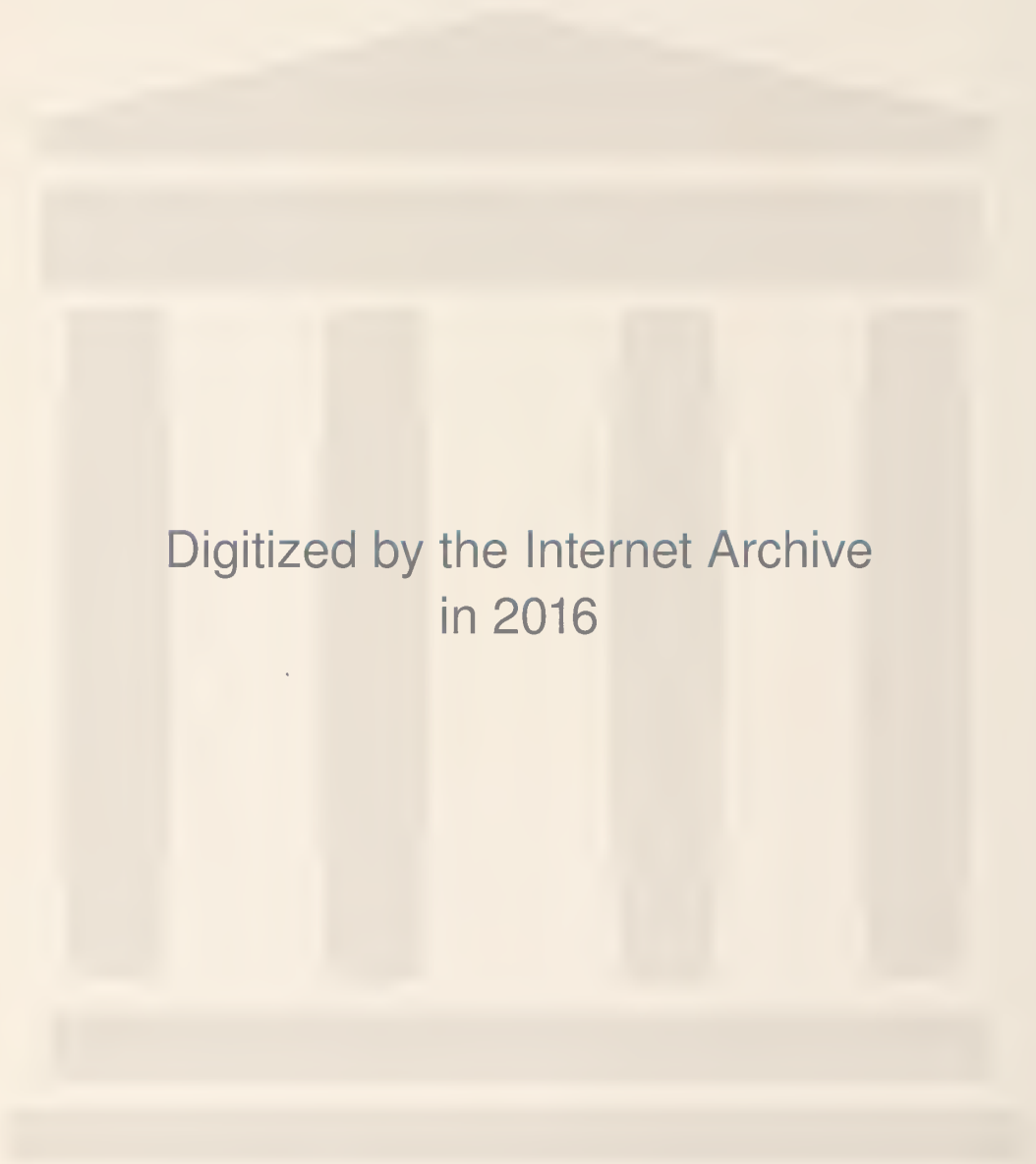
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BALCONY

the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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JULY 1969
VOL. 66, NO. 7

203rd ANNUAL MEETING
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ferences:
Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., 19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 5. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., es., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: l Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609): Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

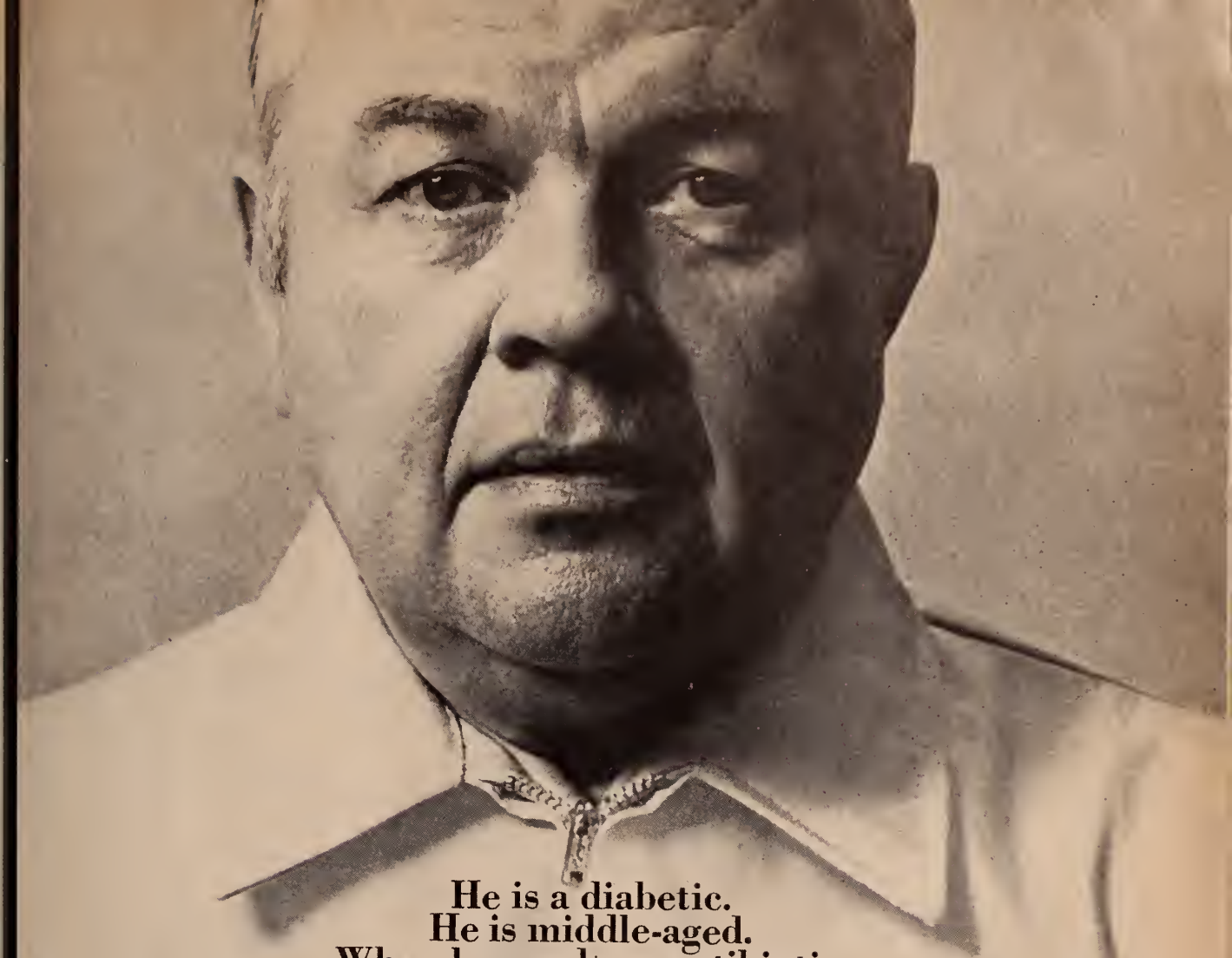
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rning: In renal impairment, usual doses may lead to excessive accum-
tion and liver toxicity. Under such conditions, lower than usual doses
indicated, and, if therapy is prolonged, serum level determinations
y be advisable. A photodynamic reaction to natural or artificial sun-
t has been observed. Small amounts of drug and short exposure may
duce an exaggerated sunburn reaction which may range from ery-
ma to severe skin manifestations. In a smaller proportion, photo-
rgic reactions have been reported. Patients should avoid direct
osure to sunlight and discontinue drug at the first evidence of skin
comfort. Necessary subsequent courses of treatment with tetracy-
es should be carefully observed.

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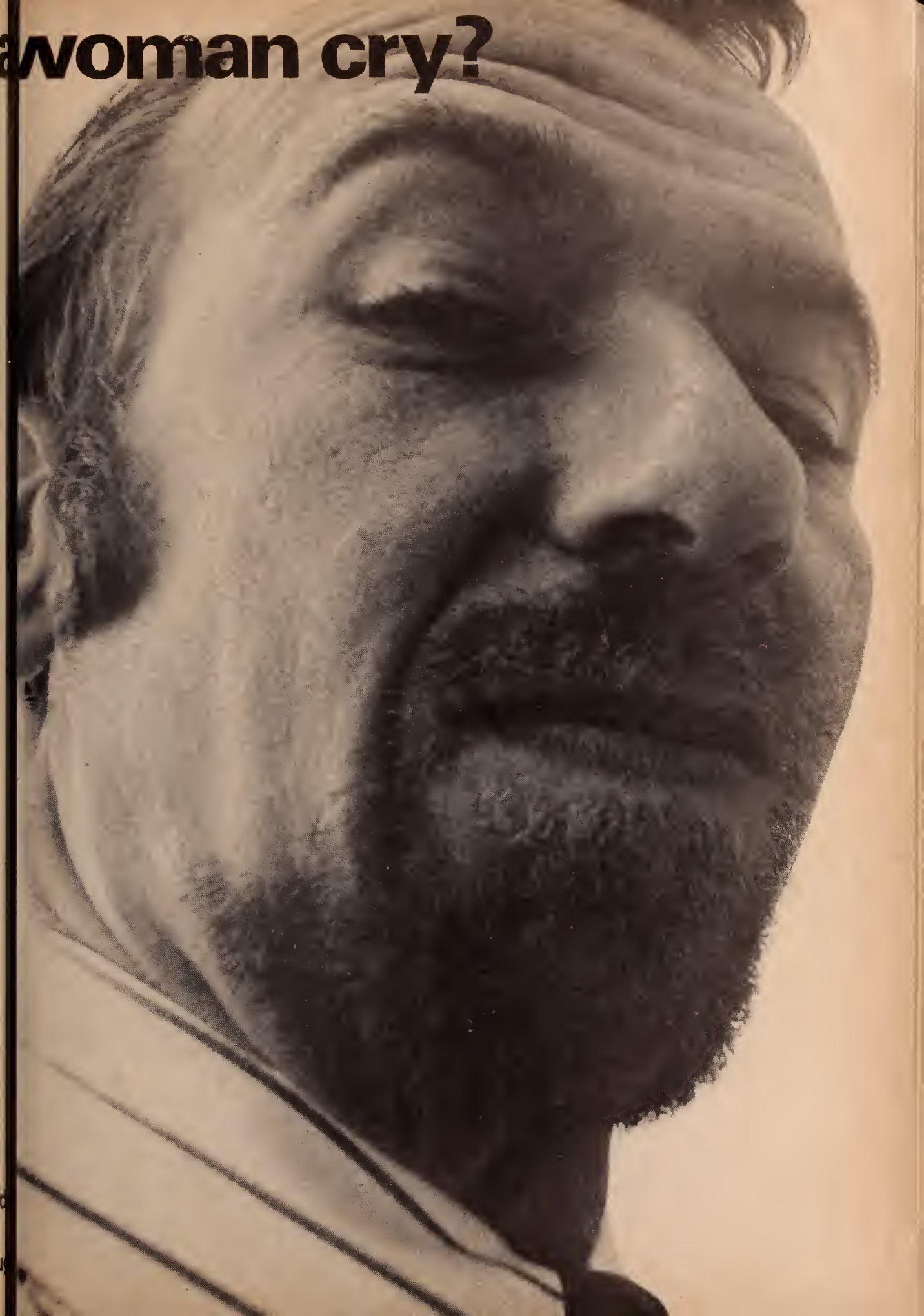
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Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
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Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
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a woman cry?



TO: MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY

SUBJECT: NEW CLAIMS PROCESSING SYSTEM

Medical-Surgical Plan is now processing claims by a more sophisticated computerized system. This is expected to result in faster payments, and will furnish providers and subscribers with detailed information regarding the Plan's determinations.

To enable this new system to function, it is imperative that the following procedures be followed explicitly in submitting claims:

1. Submit claims only on the latest Medical-Surgical Plan Service Reports, print-dated (5-68).
2. *Itemize* your *usual charges* for *each procedure or service* included in the claim.

Examples: Hysterectomy 6/21/69 $_____; removal of fatty tumor, right leg 6/21/69 $_____. Total $_____.

Application of sutures, 8-inch laceration of forehead 8/12/69 $_____; reduction of nose fracture 8/12/69 $_____; removal of sutures 8/17/69 $_____; bronchoscopy 9/1/69 $_____; Lobectomy 9/5/69 $_____; Total $_____.

EKG 8/15/69 $_____; CBC 8/15/69 $_____; ESR 8/15/69 $_____. Total $_____.

(Note: Incidental surgery—such as appendectomy in connection with hysterectomy—should not be listed.)

Failure to itemize usual charges for each procedure or service will make it necessary to return the claim to you.

The new system generates a Summary Statement voucher (for Participating Doctors) and Doctor Notification (for non-Participating Doctors) that indicate the type of services rendered, identify the Fee Schedule under which payment was made, and provide information as to why a claim was declined or a payment reduced.

During the transition period, claims in process prior to June 20 continue to be processed under the old system. Hence it is entirely possible that you have received both the old and new types of checks and Summary Statement vouchers or Doctor Notifications; by the same token, you may have found that claims submitted on and after June 20 were processed before older claims.

As with the introduction of any radical changed system, "bugs" can develop. We believe that we have anticipated and dealt with the identifiable problems, but we ask your forebearance if everything has not run perfectly from the outset. The ultimate result will be better service to you and our subscribers. However, your cooperation in following the procedures described above is vital to accomplishing this.

If you have any questions, call the Plan's Physician's Relations Section at (201) 662-2201.

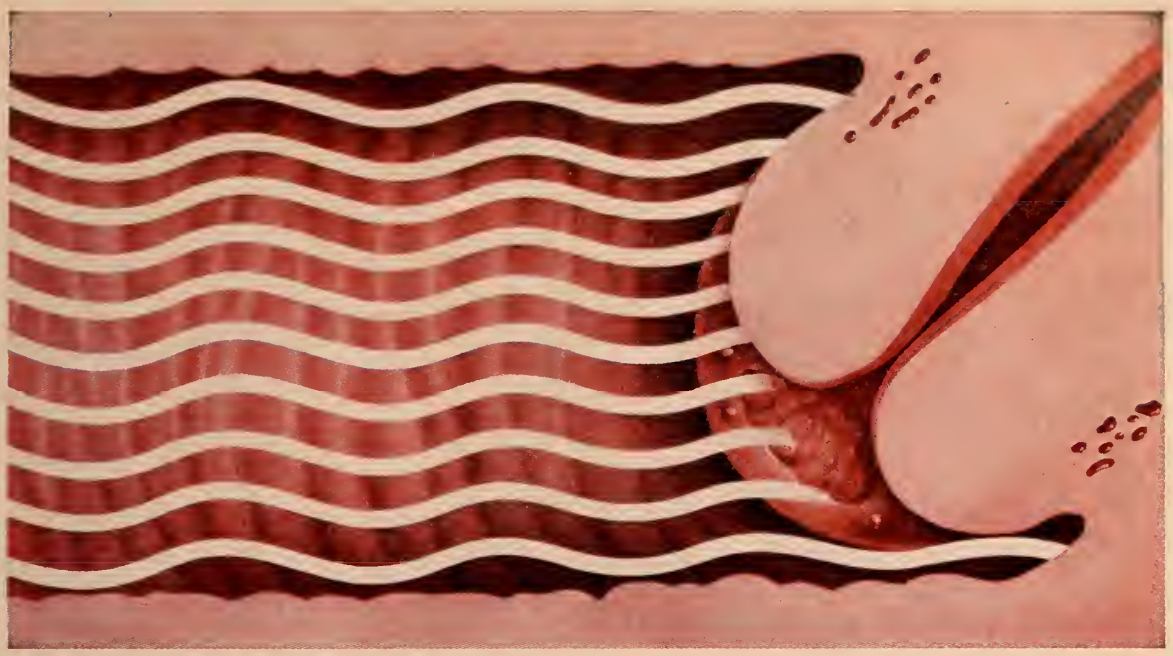
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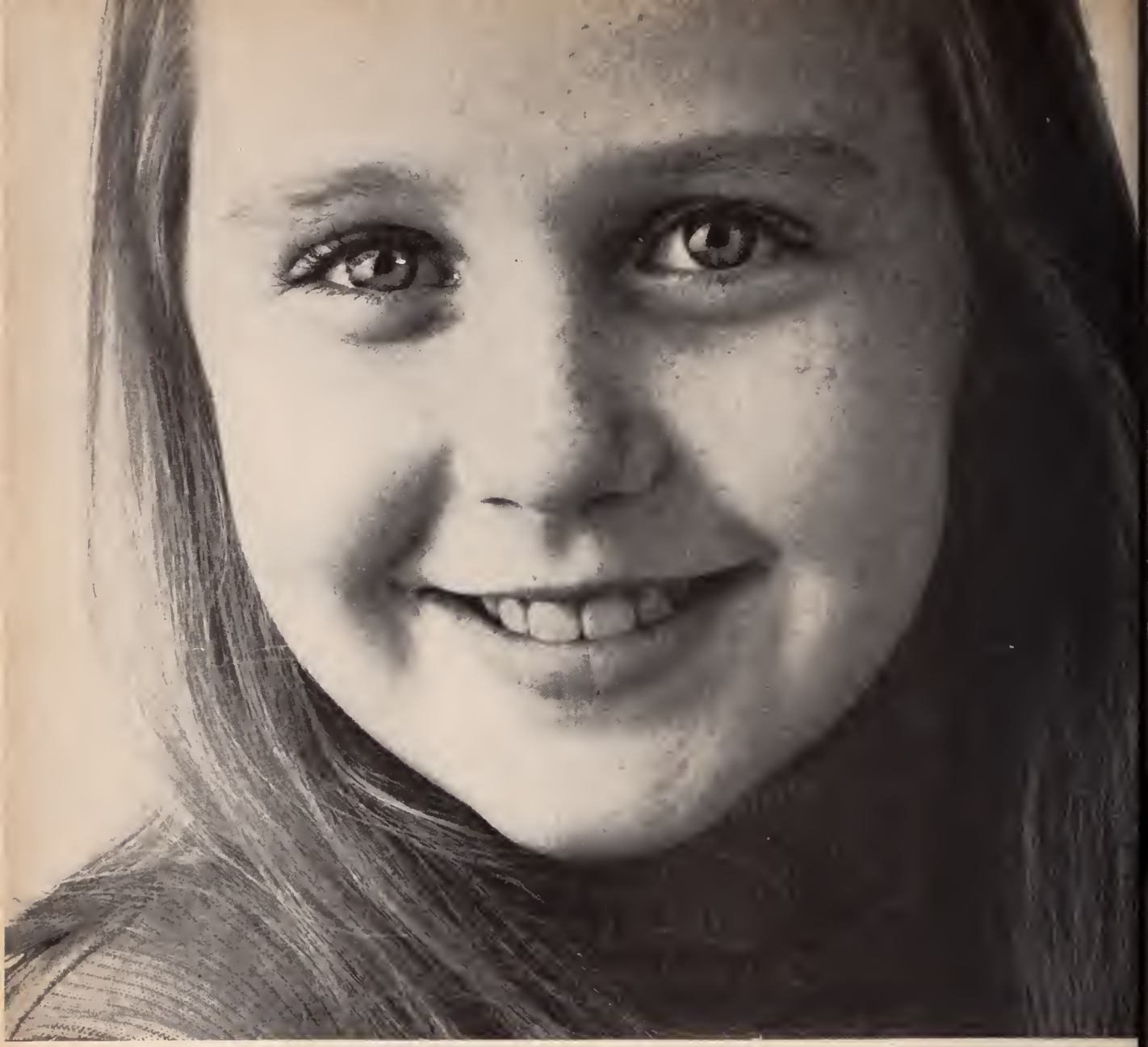


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Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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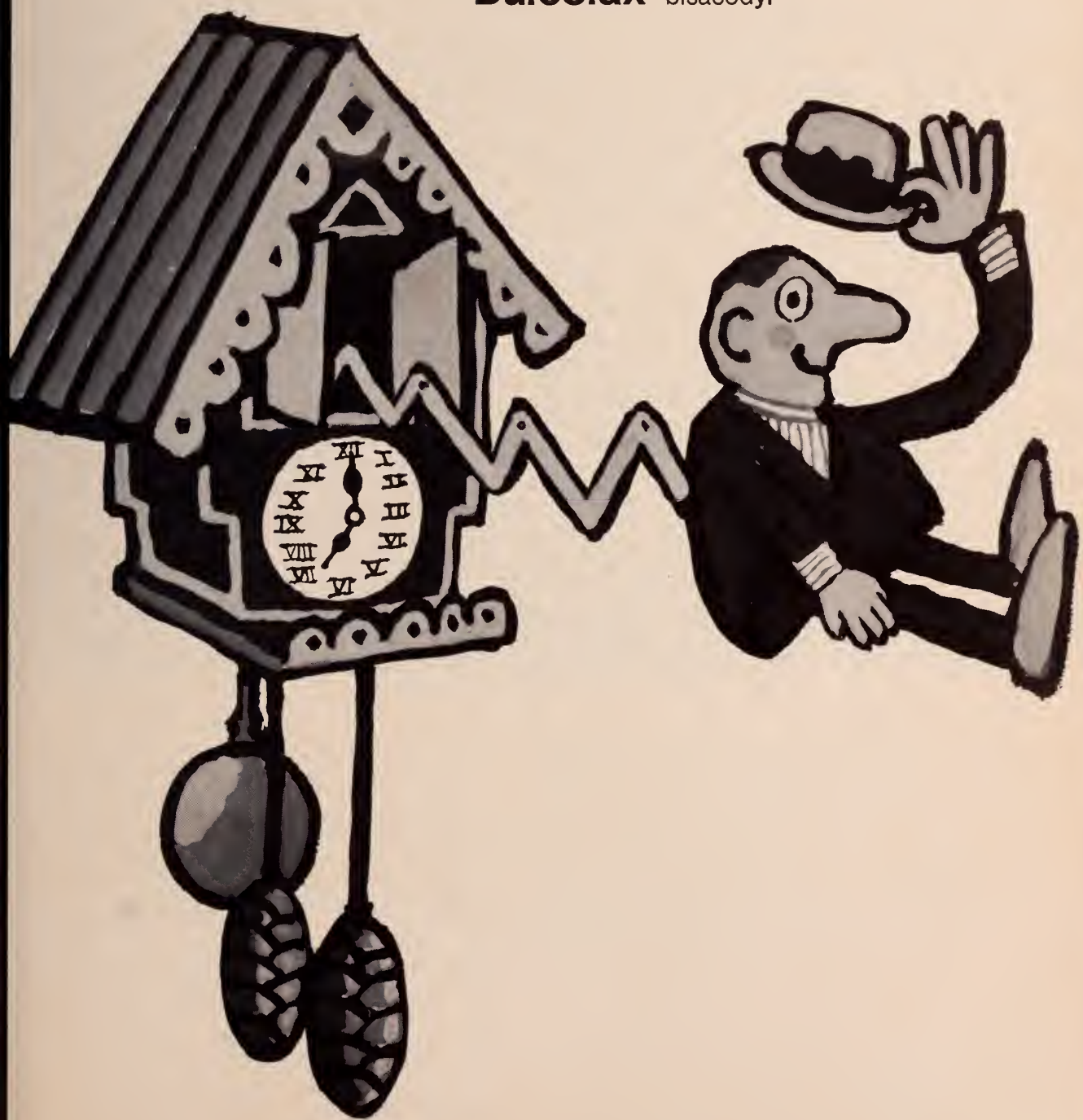
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Clues to PVD in the geriatric smoker

In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.[1]

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.[1,2] Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with *marked* peripheral vascular disease,[3] changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. *Smoking is not permissible in any stage of the disease*, since even "... minimal reduction in blood flow in patients with ischemic limbs may produce a further reduction in tissue nutrition, and thu may be another case of the proverbial straw on th camel's back."[3]

In another study of patients with peripheral vascula disease,[4] the investigators stress that decreased skin bloo flow during smoking "... is the factor of most importan to the patient with peripheral vascular disease." *Whi such patients may adjust to the discomfort of vascular i sufficiency in skeletal muscle, decreased skin blood flow m often lead to severe symptomatology.*

More and more physicians have adopted the practi of investigating for peripheral vascular disorder whe confronted with a geriatric patient who is a habitu smoker. Once a diagnosis is established, therapeut measures are directed toward increasing the peripher circulation and appropriate management of the patient general medical needs. These include the importa safeguards of keeping warm and refraining from smokin

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Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.
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Dosage: 1 or 2 Timespan Tablets morning and night.
How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

References: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., eds.: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: Proc. Med. Sect. Amer. Life Convention *51*:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. Sci. 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.

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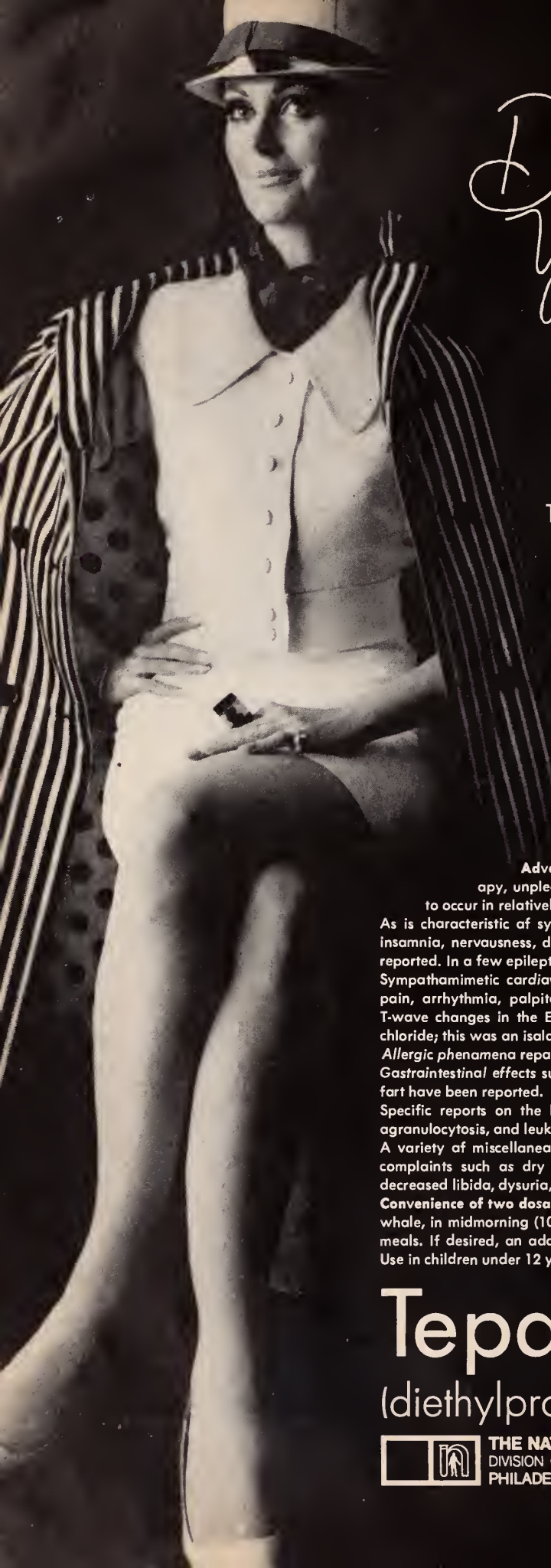
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As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

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Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

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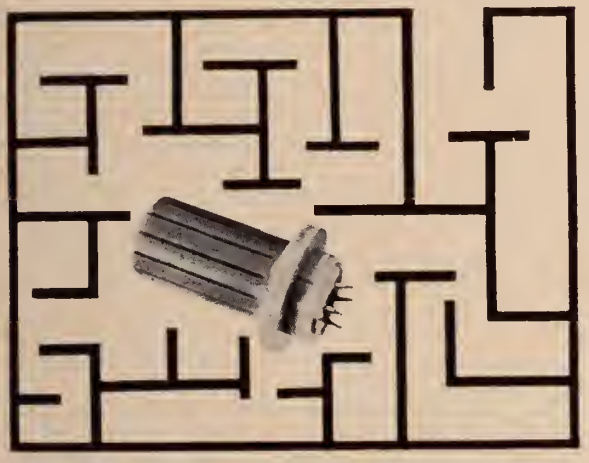
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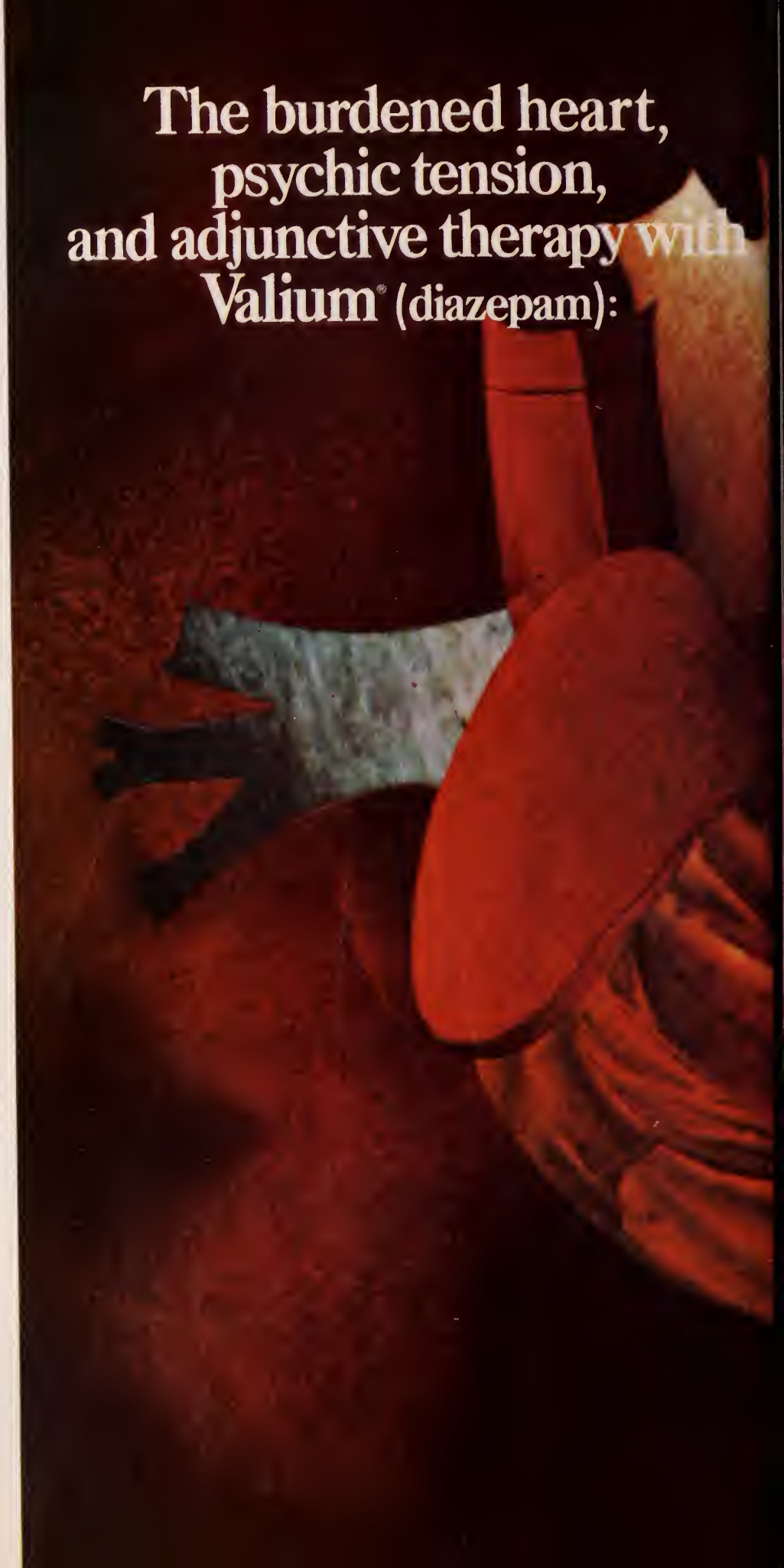
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The burdened heart...

The burdened heart, psychic tension, and adjunctive therapy with Valium® (diazepam):



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Artist's conception schematically showing varying ischemic ventricular muscle tissue.

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When the cardiac patient shows signs of panic-like reactions following initial diagnosis—a daily regimen of 10-mg Valium (diazepam) tablets *t.i.d.* or *q.i.d.* can help control *severe* psychic tension, anxiety, apprehension and agitation. For *less severe* emotional stress, the 5-mg tablet usually provides the desired calming effect.

When the cardiac patient's outlook impedes convalescence—Valium, as it relieves psychic tension, can help the patient regain a realistic perspective... help him deal more rationally with convalescence by countering excessively anxious attitudes towards the future.

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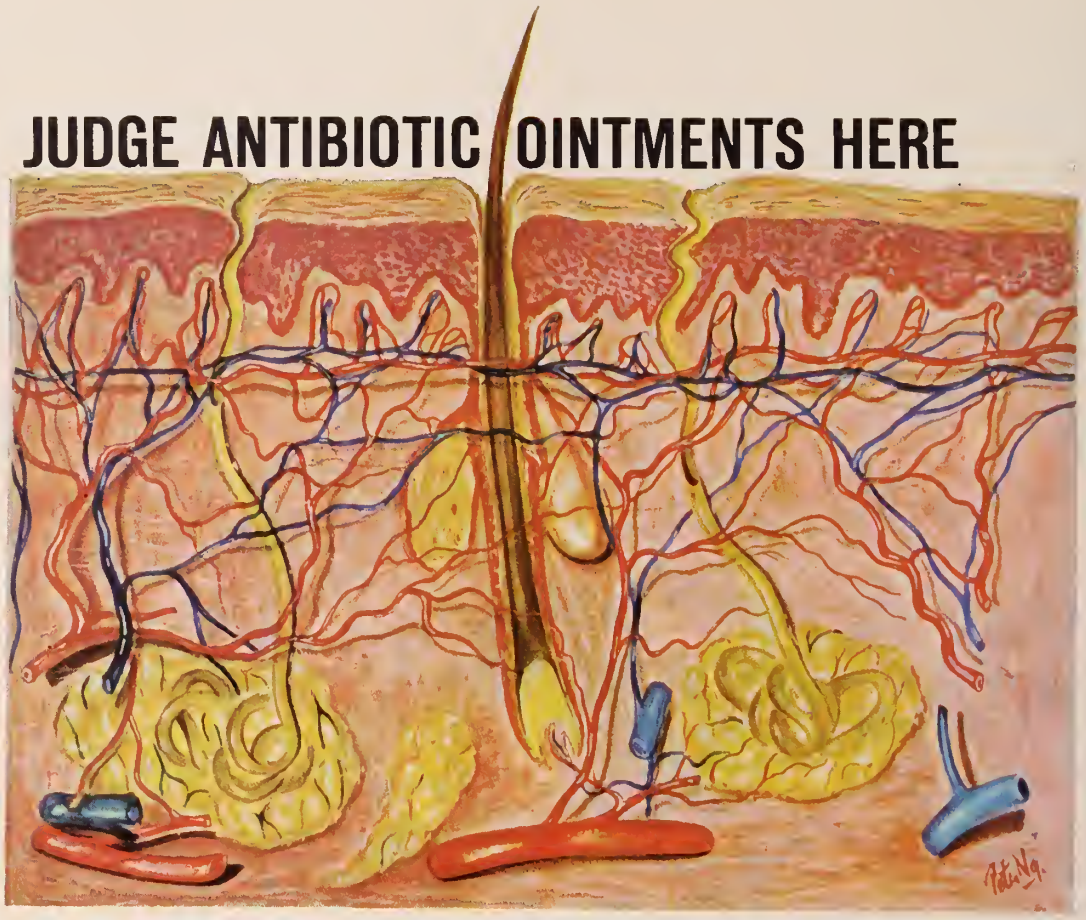
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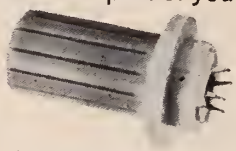
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Easy as AVC

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Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. B. Gray, L. A., and Barnes. M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:35B, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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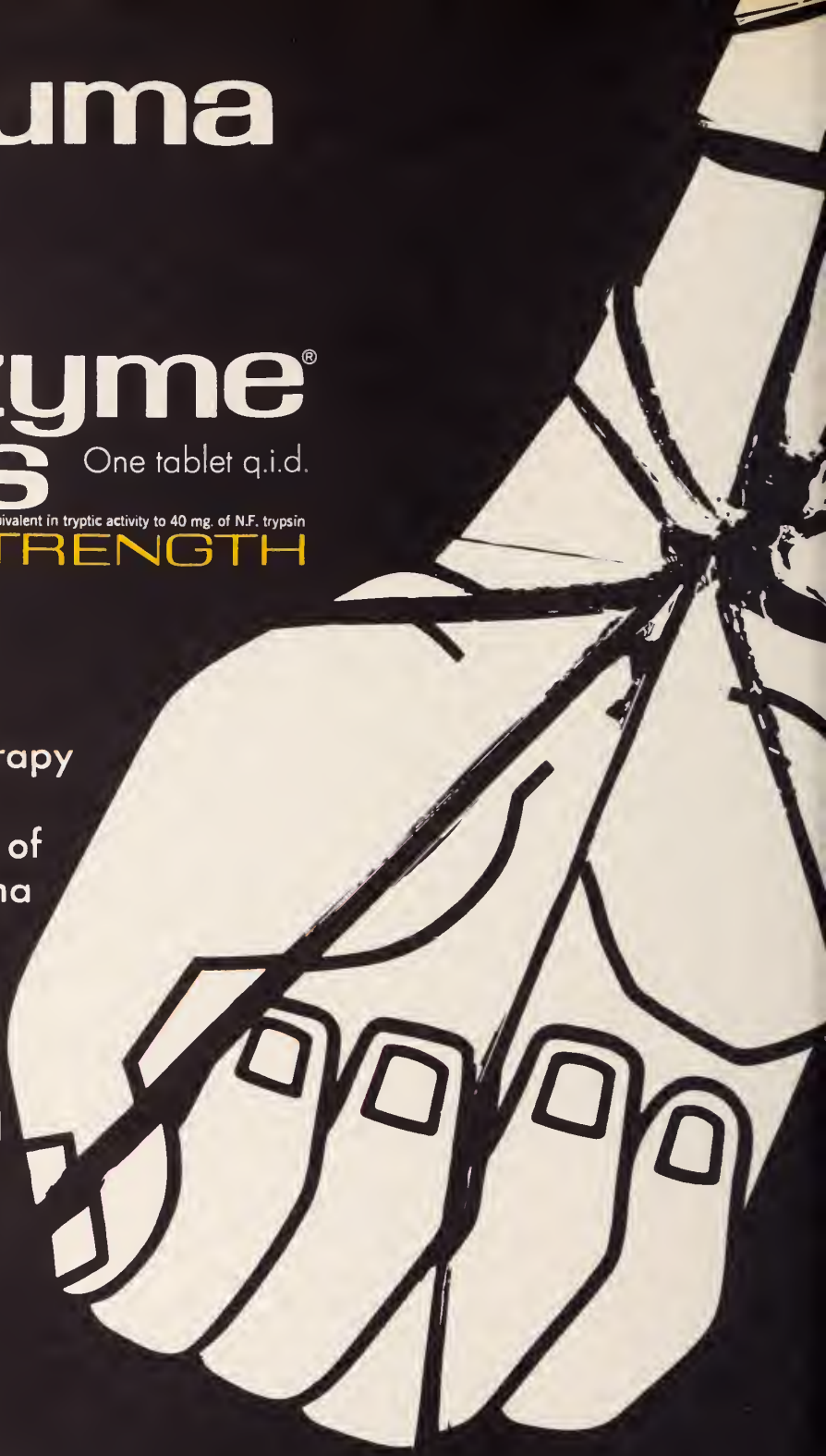
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Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies. it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

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TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

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Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens... and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

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(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5 —2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.
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EDITORIALS

The Uniform Anatomic Gift Law

The Medical Society of New Jersey has approved the Uniform Anatomic Gift Bill (A-137) which has passed in both the Senate and Assembly. This carefully worded proposed act was worked out by the Commissioners on Uniform State Laws. It represents an interesting example of cooperation between two of the major helping professions: Medicine and Law. It permits donation by any adult, in his lifetime, of any or all parts of his body. And it gives a similar power to the next of kin if the person has made no agreement of gift during his lifetime. It protects from civil or criminal liability any physician who, in good faith, carries out the transplantation. To prevent unnecessary delays, when delay would be — so to speak — fatal to the recipient, it provides for the validation of the gift by telephone, telegram, or even by tape recording. At present, most states do permit a person in his lifetime to make such agreements, but only sixteen authorize the next of kin to make such donations.

Nationwide uniformity is obviously essential. Organs are often needed from donors in other states. The vexing problem of determining the moment of death is entrusted to the physician in attendance. In April there was uneasiness about a woman who was obviously dying but who was kept alive by injections (of epinephrine, presumably) while in an airplane being flown to Texas where a desperate recipient was, almost breathlessly, awaiting a human heart. A short time after the donor arrived in Texas she was pronounced dead. Many laymen were worried that she was purposely allowed to die by withdrawing the injections, just as (the myth has it) some patients *in extremis* are allowed to die by turning off the respirator. So, there is need for this provision of the bill, too.

The Federal Government has only the powers expressly given to the Congress in the Constitution. And, of course, the founding fathers never thought of human transplants. So there appears to be no legal right to enact a single federal law on the subject. Hence the need for the awkward system of 50 uniform state laws.

Let us hope that this bill will be signed into law promptly and thus keep New Jersey in step with the 1970s.

The Growth Of The Blues

Ever since the birth of the "Blues," the big news has been their astounding rate of growth. Blue Cross and Blue Shield have hit the jackpot in public acceptance.

Occasionally one hears the suggestion that Blue Shield attempt to "stabilize" its enrollment and relax its efforts to cover an ever larger cross section of the population. But the demand for prepaid medical care is now almost universal; and those who have it are asking for broader coverage and better contracts.

Not only does Blue Shield's momentum of growth permit no turning back, but it has grown so big that the public interest in Blue Shield has made it a major item in America's program for social progress. The continued growth of Blue Shield is essential to the best interests of both physicians and the people.

Blue Shield is a major factor in medicine's economy. Whereas, installment buying creates a debt and mortgages the future, medical prepayment creates a credit for the patient, and protects his future.

Blue Shield growth is the opportunity to reduce operating costs per person enrolled. This helps the plan to broaden its services or to raise its payment to doctors — or both. Also, the greater the number of his patients covered by prepayment, the fewer for whom the doctor has a collection problem, and the lighter his load of free or part-pay work.

Medicine's most significant benefit from the growth of Blue Shield is the dominant influence of the medically guided Blue Shield Plans on the shape and destiny of the voluntary health insurance movement as a whole. Were it not for Blue Shield, the medical profession would have no effective control over the basic economy of private practice.

Drug Advertising And Editorial Policy

Like most medical journals, we publish a fair amount of drug advertising. Does this mean, that our editorial policy is shaped by the wishes and interests of our drug advertisers? In a way, the very question itself is insulting. However, Senator Gaylord Nelson of Wisconsin, chairman of a subcommittee of the U.S. Senate had, without much subtlety, accused American medical journals of following the "pharmaceutical industry's line" to get advertising dollars.

In testimony before the Senate, Dr. Maynard Shapiro (president of the American Academy of General Practice) and Dr. Edward R. Anis (an AMA Trustee) outspokenly denied this charge. They cited the high and objective advertising standards of their organizations' publications.

"The American Medical Association's programs and policies have never been shaped by any dependence on the drug industry," Dr. Annis said. "And to assure that there is no conflict of interest, the AMA has consistently separated the editorial management, advertising acceptance, and business management of each of its scientific publications."

Responding to this, Senator Nelson retorted that *after* choromycetin had been shown to be dangerous, the *JAMA* continued to carry advertisements for it, which failed to portray its hazardous side effects. Dr. Annis acknowledged that on this one occasion "a Madison Avenue effort slipped through the AMA net on advertising standards." Dr. Shapiro added that his organization's journal had "a vigilant committee of physicians to screen all advertising." Asked why the names of these screening physicians were not published, Dr. Shapiro explained that some degree of anonymity was essential for an unbiased, fearless critique; and added that all the physicians on this screening committee were on medical school faculties. The Senator asked whether any drug manufacturer had ever canceled an advertisement after the journal had published editorial or scientific matter adverse to products issued by that company. Dr. Shapiro answered, "yes" and offered to name two drug firms that had withdraw advertising after their journal went ahead with critical editorial matter.

One of the facts here can be read in two different ways. To say that a medical journal carries advertising for a product that has been criticized in its scientific pages may suggest that the journal accepts advertising indiscriminately. But it also suggests that the writers of editorials or scientific articles are not deterred for fear that advertisers will withdraw their advertising.

It is hard for *The Journal* to believe that any scientific article or Government release would be denied publication because an advertiser might be offended. Finally, there is an implication that doctors of medicine have to be protected from advertisments lest they prescribe a drug, because of the lurid advertising, without any scientific knowledge of its safety or effectiveness. This would set aside all of a clinician's experience, scientific reading, and common sense.

Official Transactions Of the House of Delegates

THE MEDICAL SOCIETY OF NEW JERSEY

203rd ANNUAL MEETING
MAY 17-20, 1969

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 203rd Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL. Actions taken by the House of Delegates are indicated in boldface small type.

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ANNUAL REPORTS

President

John F. Kustrup, M.D., Trenton

(Reference Committee "A")

Since my inauguration as the 176th President of The Medical Society of New Jersey, time has elapsed with greater speed than in any other period of my life. I am grateful for the honor you bestowed upon me. It is my hope that, with dignity and responsibility, I have been successful in bringing honor to the Society and all of you.

It has been a challenging and interesting year. Many problems are encountered, but for each problem there are many and varied solutions, with such abundance of help from many willing individuals in the Society and from other sources, that the work is not difficult but pleasurable. I am impressed with the loyalty, selflessness, zeal, and dedication which the officers and members of the Board of Trustees, Judicial Council, our councils and committees manifested in the performance of their duties. My thanks to all for a job well done.

In my visits as your President to the conventions of the Medical Societies of Pennsylvania, Delaware, New York, and Maryland I was consistently treated with great respect and friendliness. I bring to you messages of good will and assurance that our neighboring states hold The Medical Society of New Jersey in high regard.

At the AMA conventions in San Francisco and Miami Beach, our delegates worked diligently for your interests and actively in support of all the resolutions and goals which The Medical Society of New Jersey introduced or favored.

Invitations to county society meetings and annual dinners are one of the compensations of the presidency. At the meetings of component societies, I was impressed by the uniformity of reactions to our problems in medicine, and by the widespread realization of the need to adhere to the basic principles of service to our profession and to our patients, together with the need to be flexible in adapting to changes of our times as long as those basic principles are not violated. At the annual dinners of component societies we were given the pleasure of meeting the spouses of our doctors, and we enjoyed the cordiality and graciousness of our hosts.

My one year of membership on both the Board of Trustees of the New Jersey Hospital Plan (Blue Cross), and that of the Medical-Surgical Plan of New Jersey (Blue Shield), impressed me. The membership of these organizations works unselfishly in trying to effect high quality care at a reasonable cost. I am most impressed with the painstaking efforts of Dr. Joseph Donnelly in personally consulting with individual groups of physicians in an attempt to correct situations which deter them from becoming participating physicians of Blue Shield.

We were also guests at luncheon of the Woman's Auxiliary to The Medical Society of New Jersey, and dinner with the New Jersey Dental Society, Pharmaceutical Society, New Jersey Osteopathic Association, Academy of General Practice, Medical Assistants, Nurses Association, Academy of Medicine, and the New Jersey Rehabilitation Commission.

My trip to Texas, New Mexico, and Colorado — as a member of "Operation Understanding" — introduced me to what is now a very controversial subject, The Antiballistic Missile.

Some important matters which have been worked on during the past ten months and items to be considered in the future are: 1) Legislative items; 2) Medicaid; 3) The Study of a Relative Value Scale; 4) The Study and Implementation of Public Law 89-749, Comprehensive Health Planning and Public Health Services Act; and 5) Physician Procurement and Education.

Legislative Items: The report of the Council on Legislation will reflect the large volume of work accomplished. I feel obliged to comment on Senate Bills 363 and 365. These bills were passed by both the Senate and Assembly, despite our vigorous opposition. Thanks to your letters of protest to the Governor and to Wilbur Cohen's HEW report to Congress with reference to chiropractors, Governor Hughes finally filed both these bills in the State Library without his approval.

The Council on Legislation's work is now aided by the acquisition of Mr. Edward F. Meara, III, as legislative consultant, and John J. Bedrick, M.D., and Louis K. Collins, M.D., as legislative educational representatives.

Medicaid: I appeared before the joint meeting of the New Jersey Senate and Assembly Committees on Institutions and Welfare, and in New York City at an HEW-sponsored Regional Public Hearing on the Medicaid Program, to present our policy position and principles concerning the operation of Medicaid. After the bill was signed into law, I represented The Medical Society of New Jersey at a public hearing conducted by the State Commissioner of Institutions and Agencies, recommending that a qualified insurance carrier be designated to process claims and payments for charges for medical services rendered to Medicaid beneficiaries, and that payment for physicians' professional services be made on the basis of usual and customary charges.

Relative Value Scale: In view of the controversies with reference to usual, customary, and reasonable fees, I recommend that a study be made regarding the development of an updated relative value scale, and the eventual implementation of it.

Comprehensive Health Planning — Public Law 89-749: This program is aimed at establishment of a partnership in health which will bring into close relationship the resources, skills, and abilities of the public and private sectors at both state and local level. It is concerned with the physical, mental, and environmental health needs of the total population. It is in charge of the Commissioner of Health with an advisory council of 51 per cent consumers and 49 per cent providers of medical care. Physicians presently on this committee are Robert R. Cadmus, M.D., Dewitt Stetten, Jr., M.D., and John F. Kustrup, M.D. The physicians and the medical society are of necessity keystones on which this program is to be built.

I recommend that physicians organize at the county level or by Judicial Districts to plan the details of local health needs of the future for their areas.

Physician Procurement and Education: One year ago, 57 American interns were assigned to New Jersey hospitals approved for internship by the Intern Matching Plan. In this year's report, the number has been reduced to fifty-six (56). New Jersey can no longer continue as an absorber of medical talent from other states. It must expand enrollment in its present medical schools and plans must be actively undertaken to develop a new medical school in the southern part of the State. With these expansions will come improvement in the continuing education of the physician.

This year the Woman's Auxiliary made it easy for me to see, to hear, and to know the work of the Auxiliary by electing Mrs. Kustrup as its President. On behalf of the Medical Society, I express to the Woman's Auxiliary our appreciation for their untiring effort and dedication to The Medical Society of New Jersey.

In conclusion, I express my deep appreciation for all the assistance given me by everyone in the Society. To Richard I. Nevin, as my adviser, I express my sincere thanks and admiration; to the staff which has worked so industriously and in great harmony, I am most grateful.

It has been a cherished privilege to serve as the President of The Medical Society of New Jersey. I shall remember and cherish the experience as long as I live.

Approved (page 409)



President John F. Kustrup Addressing House of Delegates.



Presidential Certificate presented to Dr. Nicholas A. Bertha by Dr. Kustrup.



President Kustrup passing gavel to Incoming President Bertha.

Secretary

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

Because of illness, the Secretary was unable to attend the Annual Meeting of the American Medical Association in San Francisco, California and the Clinical Meeting in Miami Beach, Florida, in his dual capacity as MSNJ Secretary and AMA Delegate.

Membership

(As of December 31, 1968)

Active:	Paid	6,569	
	Exempt	474	7,043*
Associate:	Paid	406	
	Exempt	61	467*
State Emeritus			198
State Honorary			9
New and Reinstated Members:			
	Active	180	
	Associate	268	448
Transfers within the state			28
Transfers out-of-state and resignations			58
Members deceased			88
Members dropped:			
	Active (non-payment of dues)	32	
	(New Jersey licensure revoked)	1	
	Associate (non-payment of dues)	8	41

* Adjusted for transfers out-of-state, resignations, and deaths.

AMA Membership

A total of 6,162 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total seven delegates — one for each thousand members, or fraction thereof.

Membership Directory

In October 1968, the completion of the 1968-69 edition of the *Membership Directory* was announced. Distribution to the entire membership was made shortly thereafter.

Basically the new *Directory* embodied the same features as that of the 1966-67 edition, which includes:

The supplement section — available only in copies prepared for members — has had added to it two new laws affecting medical practitioners. It also contains the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners, and a list of Poison Control Centers in New Jersey.

Innovations made in this edition include: (1) the addition of "zip code" in the individual listing appearing directly following the street address, and preceding the telephone number: (2) the consolidation of specific and general abbreviations into one alphabetical sequence.

Again, an expression of gratitude is in order for the cooperation received from the membership in assisting us to produce this *Directory*.

Approved (page 409)

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1969 interim report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey by the Society's independent public accountants.

The Comparative Balance Sheet is presented as of 30 April 1969 and 30 April 1968 without audit or verification, for the reason that the current fiscal year of the Society does not end until 31 May 1969. Audited figures and a complete report of audit will be prepared and submitted for the year ended 31 May 1969 at a later date.

The Comparative Statement of Revenue, Expenditures and Members' Equity (Surplus) present the operations of the Society for the eleven month periods ended 30 April 1969 and 30 April 1968.

Revenues have been checked, by the auditor, in full for the period and disbursements checked to supporting vouchers. The cash balances at 30 April 1969 were reconciled with the bank statements but were not confirmed direct with the depositors. Revenue from Counties for dues' assessments were checked in detail to reports on file, but were not confirmed with the County Treasurers at this time. Investments were not physically examined.

These interim statements have been prepared in a form similar to the audited annual report, in order to show in more detail the assets, operating revenue, and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

GENERAL FUND
COMPARATIVE BALANCE SHEETS

ASSETS	*April 30* *1969*	*1968*
Cash	$124,653.87	$146,201.55
Investments — at cost	398,396.49	325,282.03
Accounts Receivable	9,379.63	9,214.05
Inventories:		
Maternal Service Record Books (contra)	3,847.44	4,510.33
"The Healing Art" books (contra)	8,566.21	8,376.97
Land, Buildings and Equipment (contra)	164,988.76	164,453.16
Other Assets	5,767.07	3,908.69
Total Assets	$715,599.47	$661,946.78

LIABILITIES, SPECIAL FUNDS AND MEMBERS' EQUITY

Liabilities:		
Unexpended Budget Appropriations	$ 71,024.44	$ 56,808.98
Library of Academy of Medicine	35,892.50	23,115.00
Journal Publication	4,787.61	5,621.10
Other Liabilities	3,480.17	1,639.40
Special Funds:		
Assessments deferred to future operations	188,425.62	148,151.78
Membership Directory	———	1,901.25
Annual Meeting	25,551.31	9,858.45
The Healing Art (contra)	8,566.21	8,376.97
House Restoration and Replacement	6,670.14	5,370.14
Maternal Service Record Books (contra)	3,847.44	4,510.33
Land, Buildings and Equipment (contra)	164,988.76	164,453.16
AMA Grant for Psychiatry Symposium	750.00	690.50
Members' Equity (Surplus)	201,615.27	231,449.72
Total Liabilities, Special Funds and Members' Equity	$715,599.47	$661,946.78

SCHEDULE OF EXPENDITURES — GENERAL FUND
For the Eleven Months Ended 30 April 1969

	Adopted Budget	*Total Expended*	*Balance Unexpended*
Administrative and Executive:			
Executive Salaries	$ 58,597.00	$ 53,807.46	$ 4,789.54
General Staff Salaries	94,351.00	76,833.08	17,517.92
General Executive Office Expenses	15,000.00	13,496.85	1,503.15
Executive Travel	3,300.00	2,404.22	895.78
House Maintenance	17,800.00	16,080.65	1,719.35
Treasurer	5,700.00	5,003.40	696.60
Finance and Budget Committee	75.00	4.32	70.68
Secretary	450.00	———	450.00
Employment Security Taxes	1,110.00	1,031.25	78.75
Federal Insurance Contributions	5,500.00	4,919.47	580.53
Federal Unemployment Insurance	280.00	264.90	15.10
Insurance	8,450.00	7,364.20	1,085.80
House Reserve	5,300.00	2,630.86	2,669.14
Welfare:			
Legislation Council	4,200.00	5,320.06	(1,120.06)
Public Health Council	2,500.00	1,258.10	1,241.90
Public Relations Council	6,750.00	3,346.28	3,403.72
Medical Services Council	700.00	207.42	492.58
Mental Health Council	1,350.00	187.71	1,162.29
Special:			
President and Presidential Officers	10,590.00	7,762.84	2,827.16
AMA Delegates	11,060.00	10,472.60	587.40
Woman's Auxiliary	5,925.00	5,046.73	878.27
Medical Educaton Committee	150.00	10.00	140.00
Conference Groups	500.00	10.00	490.00
Membership Directory	14,753.00	14,753.00	———
Emergency Medical Care Committee	325.00	17.00	308.00
Credentials and Membership Committee	250.00	215.04	34.96
Archives and History	100.00	———	100.00
Project Hope — Vietnam	6,000.00	1,500.00	4,500.00
Medical Defense and Insurance Committee	500.00	48.94	451.06
Board of Trustees	5,900.00	1,893.03	4,006.97
Contingent	10,000.00	5,220.22	4,779.78
Judicial Council	500.00	381.93	118.07
Legal	5,300.00	3,750.00	1,550.00
Medical Student Loan Fund	13,000.00	———	13,000.00
Total Budget Expenditures	$316,266.00	$245,241.56	$71,024.44

COMPARATIVE STATEMENT OF REVENUE, EXPENDITURES AND MEMBERS' EQUITY — GENERAL FUND

	For the Eleven Months Ended 30 April	
	1969	*1968*
Revenue:		
Assessments Earned	$298,763.41	$269,330.77
Income on Savings Accounts	2,700.00	6,218.75
Income on Investments	13,219.29	7,069.69
Maternal Service Record Book Sales	644.52	749.23
Miscellaneous Income	20.44	752.50
Total Revenue	$315,347.66	$284,120.94
Less Approved Budget for Year	316,266.00	288,217.00
Excess of Approved Budget over Revenue	$ 918.34	$ 4,096.06
Deduct Medical Journal Deficit	16,484.70	8,775.00
Total Deficit	$ 17,403.04	$ 12,871.06
Transfers and Adjustments — net	4,344.65	(5,648.74)
	$ 21,747.69	$ 7,222.32
Members' Equity:		
Balance, beginning	223,362.96	238,672.04
Balance, ending	$201,615.27	$231,449.72

COMPARATIVE SCHEDULE OF REVENUE AND EXPENDITURES MEDICAL JOURNAL

	For the Eleven Months Ended 30 April	
	1969	*1968*
Revenue:		
Advertising:		
State Medical Journal Advertising Bureau	$ 39,498.74	$ 46,580.00
Local	10,642.13	10,894.45
Cooperative Rebate	2,683.35	3,723.11
Classified	792.10	1,087.90
Subscriptions and Extra Copies	1,188.24	913.06
Illustrations	611.94	342.16
Reprints — net	1,215.00	1,154.88
Total Revenue	$ 56,631.50	$ 64,695.56
Expenditures:		
Publication	$ 50,050.82	$ 49,239.07
Salaries	12,010.64	11,155.64
Advertising Manager's Commission	4,638.81	6,094.49
Commissions — Local	2,844.42	3,216.29
Discounts	980.50	1,185.22
Administrative Expenses	917.72	1,066.45
Payroll Taxes	661.06	562.01
Insurance	243.10	410.20
Travel	10.40	48.63
Illustration Expense	635.74	420.05
Office Expenses	122.99	72.51
Total Expenditures	$ 73,116.20	$ 73,470.56
Excess of Expenditures over Revenue	$ 16,484.70	$ 8,775.00

MEDICAL STUDENT LOAN FUND
COMPARATIVE BALANCE SHEETS

ASSETS	*30 April 1969*	*1968*
Cash	$ 47,523.53	$ 75,533.23
Investments — at cost	97,120.23	58,409.13
Notes Receivable	177,294.00	175,969.00
Accrued Interest	740.95	812.10
Fund Balance	$322,678.71	$310,723.46

Note — The Fund balance includes $6,312.00 designated as the A. Barker Kump Memorial Grant and $5,030.00 designated as the Joseph E. Mott Memorial Grant.

MEDICAL STUDENT LOAN FUND
COMPARATIVE STATEMENT OF REVENUE AND FUND BALANCES

	30 April 1969	*1968*
Revenue:		
Contributions:		
General	$ 3,449.43	$ 2,858.00
Bicentennial Commemorative	———	600.00
Budget Appropriation for General Fund	———	13,000.00
Special Assessment of Membership	7.50	1,077.50
Income for Investments	4,727.72	3,531.12
Interest on Savings Accounts	1,199.87	1,319.51
Interest on Notes Receivable	355.23	547.49
Total Revenue	$ 9,739.75	$ 22,933.62
Less Note Charged Off	225.00	———
Net Revenue	$ 9,514.75	$ 22,933.62
Fund Balance Beginning	313,163.96	287,789.84
Fund Balance Ending	$322,678.71	$310,723.46

SCHEDULE OF STATE ASSESSMENTS COLLECTED
For the Eleven Months Ended 30 April 1969

County	*1969 Dues*	*1968 Dues*	*Net State Assessments*
Atlantic	$ 8,116.63	$ 486.66	$ 8,603.29
Bergen	38,416.47	446.82	38,863.29
Burlington	7,899.96	246.71	8,146.67
Camden	18,449.96	293.38	18,743.34
Cape May	1,766.66	80.00	1,846.66
Cumberland	4,999.99	253.34	5,253.33
Essex	70,283.08	1,893.46	72,176.54
Gloucester	4,116.64	100.03	4,216.67
Hudson	22,466.61	1,166.69	23,633.30
Hunterdon	2,566.65	373.34	2,939.99
Mercer	17,383.26	1,620.03	19,003.29
Middlesex	18,066.54	213.38	18,279.92
Monmouth	16,016.61	1,486.71	17,503.32
Morris	17,149.94	180.05	17,329.99
Ocean	5,649.98	406.68	6,056.66
Passaic	27,749.94	360.05	28,109.99
Salem	2,283.33	53.34	2,336.67
Somerset	5,566.65	400.00	5,966.65
Sussex	2,166.65	40.01	2,206.66
Union	29,949.84	553.35	30,503.19
Warren	1,949.98	133.35	2,083.33
Totals	$323,015.37	$10,787.38	$333,802.75

RECONCILIATION OF STATE ASSESSMENT ACCOUNT
For the Eleven Months Ended 30 April 1969

Unearned Assessments, 31 May 1968		$153,386.28
Net Assessments collected for period per schedule above		333,802.75
Earned Assessments for year ended 31 May 1969:		
1968 Unearned Assessments at 31 May 1968	$153,386.28	
1968 Assessment Collections	10,787.38	
1969 Assessment Collections Applicable	134,589.75	
Earned Assessments for period	$298,763.41	
Unearned Assessments at 30 April 1969:		
Assessments Applicable to year ended 31 May 1970	188,425.62	
Totals	$487,189.03	$487,189.03

SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED
For the Eleven Months Ended 30 April 1969

County	*American Medical Association Dues*	*Library of Academy of Medicine Assessments*	*Medical Student Loan Fund Assessments*
Atlantic	$ 11,410.00	$ 891.25	$ 2.50
Bergen	35,455.00	4,080.00	
Burlington	10,220.00	866.25	2.50
Camden	24,500.00	1,935.00	
Cape May	2,310.00	190.00	
Cumberland	6,230.00	540.00	
Essex	82,530.00	7,455.00	
Gloucester	5,180.00	455.00	
Hudson	25,270.00	2,435.00	
Hunterdon	3,640.00	315.00	
Mercer	24,500.00	1,995.00	
Middlesex	22,435.00	1,920.00	
Monmouth	16,310.00	1,845.00	
Morris	22,015.00	1,801.25	2.50
Ocean	7,525.00	635.00	
Passaic	24,290.00	2,880.00	
Salem	3,150.00	240.00	
Somerset	7,315.00	620.00	
Sussex	2,590.00	235.00	
Union	39,970.00	3,160.00	
Warren	2,520.00	230.00	
Totals	$379,365.00	$34,723.75	$ 7.50

SCHEDULE OF SPECIAL ASSESSMENT ACCOUNTS
For the Eleven Months Ended 30 April 1969

	American Medical Association	*Library of Academy of Medicine*	*Medical Student Loan Fund*
Balance payable, 31 May 1968	$ ———	$ 1,168.75	$ 7.50
Assessments collected for above	379,365.00	34,723.75	7.50
	$379,365.00	$35,892.50	$ 15.00
Remitted to Organizations	$379,365.00	$ ———	$ ———
Balance payable, 30 April 1969	$ ———	$35,892.50	$ 15.00

ANALYSIS OF CASH SAVINGS ACCOUNTS AND INCOME THEREON

		Balances 30 April 1969	*Rate of Interest*	*Interest Income*
General Fund:				
First Trenton National Bank				
Treasurer's General Account	$57,153.87			
Executive Account	12,000.00			
Office Petty Cash Fund	500.00			
Certificate of Deposit	15,000.00		5%	750.00
First Nat'l Bank of Spring Lake		$ 84,653.87		
Certificate of Deposit		15,000.00	5%	750.00
First Camden Nat'l Bank & Trust Co.				
Certificate of Deposit		15,000.00	5%	750.00
Police Savings & Loan Association, Newark, New Jersey		10,000.00	4½%	450.00
Total		$124,653.87		$2,700.00
Medical Student Loan Fund:				
First Trenton National Bank				
Treasurer's Checking Account		$ 17,523.53		
Savings Account		15,000.00	4%	599.87
United Savings & Loan Association, Trenton, New Jersey—Savings Account		15,000.00	4%	600.00
Total		$ 47,523.53		$1,199.87

SCHEDULE OF INVESTMENTS AND INCOME EARNED
30 APRIL 1969

Description	*Basis*	*Cost*	*Maturity Value*	*Interest Income*
General Fund:				
U. S. Treasury Bills, due 5/ 1/69	6.16	$ 34,454.35	$ 35,000.00	$ 545.65
U. S. Treasury Bills, due 6/23/69	6.16	34,179.52	35,000.00	498.00
U. S. Treasury Bills, due 7/17/69	6.18	34,122.78	35,000.00	408.00
U. S. Treasury Bills, due 8/14/69	6.12	33,964.60	35,000.00	404.60
U. S. Treasury Bills, due 9/11/69	5.98	34,023.27	35,000.00	197.54
U. S. Treasury Bills, due 9/18/69	6.01	33,977.47	35,000.00	198.56
U S. Treasury Bills, due 10/23/69	6.16	33,909.40	35,000.00	36.00
12 Federal Land Banks, due 4/20/70	6.20	20,162.50	20,000.00	1,136.67
Federal National Mortgage Association, due 12/12/69	6.00	20,137.50	20,000.00	1,100.00
Great Northern Railing Equipment Trust Certificate, due 3/1/73	6.00	20,000.00	20,000.00	1,100.00
Federal National Mortgage Association, due 4/8/71	6.30	20,000.00	20,000.00	1,155.00
Southern Railway Equipment Trust Certificates, due 3/1/71	6.00	20,000.00	20,000.00	1,100.00
Export-Import Bank Debentures, due 4/30/73	6.15	20,000.00	20,000.00	(3.42)
Southern Railway Equipment Trust, due 11/1/72	6.12	19,465.00	20,000.00	163.42
Federal Home Loan Bank Bonds, due 3/25/70	6.00	20,000.00	20,000.00	120.00
Total Investments		$398,396.49	$405,000.00	
Income from Investments redeemed during the period				5,059.27
Total Interest on Investments				$13,219.29
Medical Student Loan Fund:				
U. S. Treasury Bills, due 7/24/69	6.10	$ 33,968.08	$ 35,000.00	$ 527.77
U. S. Treasury Bills, due 9/11/69	6.00	29,165.00	30,000.00	165.00
U. S. Treasury Bills, due 10/24/69	6.00	33,987.15	35,000.00	33.18
Total Investments		$ 97,120.23	$100,000.00	
Income from Investments redeemed during the period				4,001.77
Total Interest on Investments				$ 4,727.72

Approved with commendation to the Treasurer on his detailed report, especially the last page which included the investments and income earned. It was noted that there is a marked increase in the per cent of return over previous years. (page 412)

Board of Trustees

Frank J. Hughes, M.D., Chairman, Camden

(Reference Committee "A")

Full minutes of the meetings of the Board of Trustees have been distributed regularly to component societies, and summaries of its significant actions have been highlighted in *The Journal*. Therefore, as has been the custom, this report of the Board of Trustees will cover only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

The Society's business continues to make heavy demands upon the time of the Trustees. Since its last report to the House, a total of 11 meetings of the Board will have been held. Board attendance at these meetings was excellent; all Trustees served loyally and diligently.

Dr. Louis F. Albright of Spring Lake was reelected by the Board to continue serving as its Secretary during the past year. Special commendation is due him for his conscientious performance in processing all Board correspondence and meeting notices.

Routinely, the Board has dealt with matters of all kinds arising out of its responsibilities or brought to its attention, including correspondence and resolutions from members, component societies, the American Medical Association, and outside organizations. It has appointed representatives to local, state, and national meetings of concern to MSNJ; acted on reports and recommendations of the Society's councils and committees; and cooperated with allied organizations and various departments of state government.

The Board of Trustees will have two more meetings before the first session of the House of Delegates. The items from those meetings which must be directed to your attention will be the subject of a supplemental report to the House.

Approved (page 409)

Implementation of Constitutional Amendment Affecting Membership of Elected Trustees on the Board

(Reference Committee "A")

At the closing session of the House of Delegates (21 May 1968) among the actions taken was the adoption by formal vote of an amendment to the Constitution, in accordance with which elected members of the Board of Trustees will hereafter be on the following basis:

Two Trustees from each judicial district for membership up to 1,000. One additional Trustee for each additional 1,000 members or major fraction thereof, computed as of 31 December . . . each for a three-year term.

At the reorganization meeting of the Board of Trustees held on 22 May 1968, question was raised as to whether or not the Board should act to bring the total of its members up to the levels authorized by the new constitutional amendment. The judicial districts affected are the first and second. The Board tabled discussion of the matter until its meeting scheduled for 17 July 1968, pending an official opinion and ruling by the Society's Acting Legal Counsel.

Meeting on 17 July, the Board lifted the tabled item and received and accepted the requested opinion supplied by Counsel. The opinion holds that it is not within the purview of the Board, under the Bylaws, to designate incumbents for the new Board positions created by the House's adoption of the constitutional amendment involved. Component societies were informed of the foregoing and supplied with a copy of Counsel's opinion.

Approved (page 409)

MSP Board of Trustees — Nominations
(Reference Committee "C")

The following nominations were approved by Board and are referred to the House of Delegates for action:

Not included in the preceding list of members serving on the Board of Trustees are the following: Chairman of the Board of Trustees of Hospital Service Plan of New Jersey, President of the New Jersey Hospital Association, and President of The Medical Society of New Jersey. These three people serve during their respective terms of office of the organizations indicated.

Approved (page 413)

Three-year term (1969-1972):

Name	*Type of Practice*	*Member of Component Society*
Donald T. Akey, M.D.	Surgeon	Middlesex County
Robert G. Boyd	Hospital Administrator	—
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cunniff, M.D.	Internist	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiologist	Monmouth County
Sidney I. Simon, Ph.D.	College Professor	—
Warren H. Simmons	Businessman	—
Morgan Sweeney	Labor Leader	—
Robert E. Verdon, M.D.	General Practice	Bergen County

One-year term (1969-1970):

Stanley C. Van Ness	Lawyer	—

The following persons will continue membership on the Board until the expiration of their terms in the year indicated—or until their successors are elected and qualified:

Terms expiring 1970	*Type of Practice*	*Member of Component Society*
Edgar P. Eaton, Jr.	Businessman	—
Joseph I. Echikson, M.D.	Internist	Essex County
Edwin T. Ferren, D.O.	General Practice	—
Mortimer J. Fox, Jr.	Businessman	—
Jerome G. Kaufman, M.D.	Internist	Essex County
Joseph M. Keating, M.D.	Obstetrician	Passaic County
Elton W. Lance, M.D.	Surgeon	Union County
Henry J. Mineur, M.D.	Internist	Union County

Terms exipring 1971	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathologist	Essex County
James T. Crowley	Businessman	—
Lloyd M. Felmly	Retired Newspaper Editor	—
Samuel J. Lloyd, M.D.	Surgeon	Mercer County
Theron L. March	Banker	—
Jesse McCall, M.D.	Internist	Sussex County
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County
Thomas J. White, M.D.	Internist	Hudson County

Joint Conferences With Presidents of Component Societies
(Reference Committee "A")

The Board continued the precedent of sponsoring, in the fall and spring, informal conferences for presidents and presidents-elect of component societies. The first conference was held on Sunday, 20 October 1968. A total of twenty-five presidents and/or presidents-elect represented sixteen component societies. The second conference was held on Sunday, 16 March 1969. A total of twenty-three presidents and/or presidents-elect represented eighteen component societies.

The various items covered informally by this group have been reported in *The Journal* and thus need not be reflected here.

At the meeting of the Board in March of 1968, confusion seemed to exist concerning the actual scope and purpose of the authority of the informal group. The Board was unanimous in its agreement that a formal statement outlining these areas would be helpful for conference participants, in the future. At that time, the Board referred the matter to the Executive Committee with the request that it draw up proposed guidelines for the activity of the group, for submission to the Board in advance of the fall (20 October 1968) conference. In conformity with the foregoing, the Board approved the following guidelines submitted by the Executive Committee:

The first "Conference of Presidents of Component Societies" was held on Sunday, 18 October 1964, at the invitation and under the sponsorship of the Board of Trustees. Subsequently, two such conferences have been held each year—in the Fall and the Spring—and presidents-elect as well as presidents of component societies have been invited to attend.

The Board of Trustees, in its report to the House of Delegates in May, 1965, declared that ". . . the purpose of the informal meetings of presidents of component societies and the joint meeting with the Board of Trustees (which customarily follows) is to give component society presidents and/or presidents-elect a forum for free and open discussion with one another and with members of the Board, to encourage improved mutual understanding of problems of MSNJ as well as those of component societies. It was thus agreed that as an informal discussion group, county officers have no authority to act as a unit—either for themselves or for their component societies."

Underlying the conference is the realization that since component societies have many common problems to resolve and similar situations to deal with, it would be informative and profitable for presidents and presidents-elect to learn how other component societies are proceeding and the experiences that have been developed.

The subsequent meeting with the Board is intended to provide the conferees with an appreciation of the scope and operations of the Board of Trustees and to afford the opportunity for exchange of constructive ideas. Recommendations for study and action by the Society should come from the Conference of Presidents to the Board, but should, as in the past, be initiated by formal action of component societies or authorized delegates, submitted by due process to the House of Delegates in the form of official resolutions.

It was the opinion of the conferees that these meetings continue to be successful and profitable and should be continued—at least twice a year, as has been the custom.

Approved (page 409)

Professional Liability Panel
(Reference Committee "A")

The Administrative Director of the Courts has rendered a summary report as of 31 December 1968, indicating the Courts' experience in handling claims under the Supreme Court Rule 4:25B (concerning the use of subpanels on professional liability claims).

	1966	1967	1968
Number of claims filed	35	51	40
Number of doctors involved	51	68	58
Number of cases where doctors refused consent	9	12	3
Number of claims withdrawn	5	8	5
Number heard by subpanels	21	19	6
Pending cases	—	12	26
Number of subpanel hearings (by year)	21	12	18
Result of subpanel hearings			
Reasonable basis *	7	5	5
No basis **	15	7	13
Cases in which expert witnesses were furnished	—	6	—

* One case had two allegations of negligence. The panel found a reasonable basis on one count, and no basis on the other.

** One case involved two doctors — one consented and the other refused.

The Board recorded its gratification with these results as well as continued indications that the program has generated national attention and interest. For these reasons, the Board directed that the foregoing information be referred to the House, together with the following recommendation:

Recommendation

That the professional liability claims panel program be continued, and that the members of MSNJ be encouraged to continue to cooperate in its furtherance.

Approved (page 409)

Health Facilities Planning Council for New Jersey

(Reference Committee "B")

Once again the Health Facilities Planning Council for New Jersey solicited funds from non-government sources to support its 1969-70 operations. The Board received assurances from the Council that it will continue to function as a statewide voluntary planning agency as long as it is possible to do so. Dr. Kandle, a trustee of the Planning Council, has reported as seeing no inconsistency in having the Council remain as a statewide body at least for another year while the State Department of Health is organizing areawide comprehensive health planning councils under P.L. 89-749. On that basis, the Planning Council submitted its grant application for the fiscal year 1 July 1969 to 30 June 1970.

In view of the foregoing, the Board authorized a $5,000 contribution to the Health Facilities Planning Council for the fiscal year 1969-70.

Approved with the following notation: That the $5,000 contribution authorized for the fiscal year 1969-70 should be only on an annual basis and that each year the work of the Health Facilities Planning Council be reviewed before any further contributions are made (page 412)

Health Insurance for Pregnancy

(Reference Committee "C")

Two resolutions bearing upon health insurance coverage for pregnant women were adopted by the 1968 House of Delegates.

Resolution #9 called upon MSNJ to attempt to persuade members of the Health Insurance Council and New Jersey Blue Cross and Blue Shield to make maternity benefits available to all females regardless of marital status or length of time of marriage.

The Health Insurance Council found that such coverage on an individual basis would involve prohibitive costs. However, it pointed out that ". . . as a practical matter, an unmarried female who is an employee under a group contract is actually covered for maternity benefits, but not dependent children."

Some actuarial figures on probable costs for such coverage under an individual health insurance policy were submitted by the Health Insurance Council. These costs are based upon morbidity analyses which are compiled each year. As a rider on basic hospital insurance, individual policy, the cost of maternity benefits for the age group 20 to 24 years would be $11 for every $100 of benefits paid. The costs are somewhat reduced in subsequent years because of the decrease in probability of pregnancy. In the age category of 25 to 29 years, the cost would be $32 per $100 of benefits. The Health Insurance Council feels that from an actuarial standpoint, the premium costs would be prohibitive as a sales item. Furthermore, ". . . there is a great deal of selectivity in that the person desiring coverage can elect to enroll with some idea of a predictable event."

The President of the New Jersey Blue Shield Plan declared: "This has been considered previously by the Blue Shield Plan and at the present time this type of maternity service is covered in several groups, such as united steel workers and auto workers, which are experience rated and the companies are willing to pay for the additional benefit. However, we cannot include this type of coverage under the basic contract because this would include maternity service under all single contracts, under the student contracts, and would also include maternity services for all children under 19 under the family contracts. This would necessitate a great increase in the premium for all three million subscribers who are now covered and who are not interested in this type of coverage. This could increase the cost of a single contract by as much as 20 per cent and 99 per cent of the single subscribers would not wish this additional benefit so I do not see how we could add this to our basic coverage at this time."

The Blue Cross Plan has not as yet submitted a reply.

Resolution #10 called upon MSNJ to petition the Hospital Service Plan of New Jersey to show leadership in correcting the inequity that lies in the fact that, under Blue Cross insurance, coverage is not separately accorded to the complications of pregnancy but such complications are charged against the seven-day total of coverage assigned as maternity benefits.

The need and desirability of expanding the Blue Cross coverage in this regard was stressed in correspondence and in a protracted meeting of the Permanent Committee on Blue Cross-Blue Shield. The Blue Cross Plan is very sensitive to the increased premium cost that the expanded coverage will entail. It is weighing the proposal painstakingly, but as this report is compiled has not arrived at any conclusion.

Approved (page 413)

Standardized Insurance Forms
(Reference Committee "C")

The 1968 House (Resolution #31 — Camden County) called upon the AMA House of Delegates to urge all insurance companies and fiscal intermediaries to adopt and authorize the use of standard forms in the manner indicated, in the interest of increased efficiency. A resolution (#72) was introduced and supported by New Jersey's delegation at the AMA meeting. The reference committee to which it was referred declared: "Resolution #72 calls for continued support of the use of standardized insurance forms. Your reference committee recommends adoption of resolution #72 as a re-endorsement of this mechanism, which has been the subject of numerous reports to this House." The House then voted to adopt the resolution.

Received as informative, since the House of Delegates of the AMA in Resolution #72 of 1968 conformed with MSNJ's resolution of 1968 (page 413)

Hospital Chaplaincy Program
(Reference Committee "D")

The 1968 House (Resolution #6 — Essex County) called upon MSNJ to recommend to the New Jersey Hospital Association that each hospital in New Jersey support a chaplaincy program by providing space for same and, wherever possible, financial support.

At its 12 June meeting, the Board of Trustees of the New Jersey Hospital Association voted to support a hospital chaplaincy program in hospitals in New Jersey.

Approved (page 415)

Commission to Study Abortion Statutes
(Reference Committee "E")

In the early fall the Abortion Law Study Commission, created by Assembly Concurrent Resolution Number 24 (1968) was constituted. After some initial difficulty, the Society succeeded in having Hannah E. Seitzick-Robbins, M.D. (Trenton) appointed as the representative of MSNJ.

The Society's policy statement on therapeutic abortion, adopted by the 1968 House of Delegates, was supplied to the Commission. Under date of 27 November, the Board of Trustees formally requested that the Commission con-

sider for inclusion in any subsequent recommended revision of the statutes governing therapeutic abortion the following two provisions:

(1) No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or other recriminatory action against him.

(2) No hospital, hospital director, or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit such procedures shall not be ground for civil liability to any person nor a basis for any disciplinary or other action against it by the State or any person.

As yet the Commission has not published a report of its findings or recommendations.

Approved (page 416)

Mandatory Inclusion of Physicians As Members of Hospital Governing Bodies
(Reference Committee "E")

The 1968 House — substitute resolution for Resolutions Nos. 1 (Bergen), 13 (Morris), and 16 (Union) — called upon the AMA House of Delegates to urge the Joint Commission on Accreditation of Hospitals to include in its basic accreditation criteria a provision to require each hospital to include on its governing body a substantial number of physicians in active private practice. A resolution (#71) was introduced and supported by New Jersey's delegation at the AMA meeting. Resolution #71 was considered by Reference Committee "D" together with a similar resolution (#48) from Louisiana. The reference committee endorsed the intent of both resolutions and offered a substitute for the two of them, which the AMA House amended slightly and adopted, as follows:

"Resolved, that the House of Delegates reaffirms its strong conviction that full and effective communication between the governing board of a hospital and its medical staff is essential to maintain the optimum conditions for good medical care; and be it further

Resolved, that the House of Delegates continue to urge that adequate representation of the medical staff on the voting membership of the hospitals' governing body, nominated by the medical staff, is the most effective mechanism for assuring a working communication; and be it further

Resolved, that the seven AMA Commissioners on the Board of Commissioners of the Joint Commission on Accreditation of Hospitals be instructed by the Board of Trustees to reemphasize their efforts toward accomplishing these objectives."

Approved (page 416)

Review of Medical Practice Statutes
(Reference Committee "E")

In 1967 the House of Delegates adopted a Substitute Resolution for Resolutions #7 and #8. The "resolved" called for the President to establish a committee to review all statutes related to the practice of medicine and surgery in this State and to submit specific recommendations for revision to the Board of Trustees.

At the 17 May 1967 meeting of the Board of Trustees, the President appointed a committee to implement the foregoing. We were informed by both Legal Counsel and the Legislative Analyst that an undertaking of this nature would require at least two years. In the course of carrying out its charge and with the approval of the Board of Trustees, the committee secured and made available to all component societies an updated version of the Medical Practice Act. In so doing, request was made of the component societies that they enumerate the areas of concern and transmit their suggestions to the committee by January 1968. Thus far, replies have been received from three of the component societies. Through the efforts of the Council on Legislation and with the approval of the Board, several of the revisions incorporated in the three replies have already been introduced and enacted into law. They are:

1. Priviliged Communication
2. The X-Ray Technicians Law
3. Licensing of foreign physicians who, upon declaration of intent to become citizens, have been duly admitted to and passed the New Jersey medical licensure examination.

On 14 January 1969, SJR-10 was introduced into the New Jersey Senate. This bill would establish a Commission to study and evaluate the effectiveness of existing laws, rules, and regulations relating to the practice of all branches of the healing arts.

In early March of 1969, Governor Hughes pocket-vetoed three chiropractic bills and also an MSNJ bill to prohibit the solicitation of patients by or on behalf of practitioners of the healing arts. The Governor stated that these bills have led him to call for a thorough review of professional and occupational licensing.

Mindful of the foregoing, the committee recommended to the Board of Trustees that no action be taken in this area until the aforementioned reports and evaluations are completed by the Legislature.

Approved (page 416)

Concerning Welfare Recipients
(Reference Committee "E")

The 1968 House of Delegates adopted two resolutions bearing upon welfare recipients.

Resolution #7 . . . called upon MSNJ to petition the Department of Institutions and Agencies to establish the principle throughout New Jersey that diagnostic, laboratory, and medical specialty services be allowed when found necessary by the treating physician, and that compensation be made on a realistic, reasonable, and customary fee basis.

Resolution #8 . . . directed that MSNJ petition the Department of Institutions and Agencies to bring physicians' fees for services paid by all welfare boards in the state up to a realistic level on a reasonable and customary fee basis.

These resolutions were transmitted to the Commissioner of Institutions and Agencies, and correspondence with the department subsequently has established that it is the intention of the department, through the Division of Public Welfare, to give careful study to these submissions of The Medical Society of New Jersey and to engage in discussions of these matters with appropriate representatives of the Society. At the present writing those discussions have not been entered upon, and the Department of Institutions and Agencies seems to have concentrated its attention up to the present on the work of evolving a functioning Medicaid program. The Society will continue to press for further developments in effectuation of the intent of both resolutions and will reflect any such developments that occur before the 1969 Annual Meeting in a supplemental report to the House.

Approved (page 417)

Community Health Week in the Spring
(Reference Committee "F")

The 1968 House (Resolution #5 — Essex County) called upon the AMA to change Community Health Week to a date in March, April, or May. The AMA's response in part stated . . . "That those societies that find it more desirable to have the observation in the spring be urged to establish dates of their own choosing for a spring observance . . . Under such an arrangement, each state will be able to choose the time best suited to local needs."

Approved (page 422)

Revision of FAA Medical Examination Form for Pilot Certification
(Reference Committee "H")

Resolution #3, as adopted by the 1968 House of Delegates, mandated that MSNJ record its dissatisfaction with the FAA Medical Examination Form for Pilot Certification in that physicians releasing information to the FAA in regard to disqualifying physical conditions of pilots were not immune from suit for so reporting.

On 5 June 1968, this position was transmitted to the Federal Aviation Administration in Washington. Subsequently, we have been informed that legislation is being proposed by the Department of Transportation that would render a physician immune from suit for reporting significant disqualifying conditions in airmen to the FAA.

Approved with the following suggestion: That a follow-up be made to insure passage of the required legislation to render physicians immune from suits for reporting disqualifying conditions in airmen to the FAA (page 426)

Supplemental Report #1

As the result of its 20 April meeting, the Board of Trustees directed several items to the attention of the 1969 House of Delegates. The Board therefore submits this Supplemental Report #1, which has been compiled since the preparation of its annual report.

The Board is scheduled to meet next in Atlantic City prior to the opening session of the House. The results of this meeting will be the basis for Supplemental Report #2 to the House, to bring the members up to date on relevant items.

Academy of Medicine of New Jersey

(Reference Committee "B")

At the request of the Committee on Finance and Budget, an invitation was extended to the President of the Academy of Medicine of New Jersey to attend the 20 April meeting of the Board to set forth the status of finances and operational activities of the Academy in the past year. Dr. Robert H. Areson, President-Elect of the Academy, was present at the meeting to discuss the following financial statement and educational program:

Income:	
Academy Dues	$ 31,860
The Medical Society of New Jersey	35,000
Other Grants & Donations	10,135
Specific Meetings	22,815
Library Income	12,188
Bulletin Income	3,137
Dividends and Interest	690
Miscellaneous	575
Total Income	$116,400

Expenses: Education	
Salaries & Wages	$ 20,926
Overhead	8,848
Meetings & Programs	31,247
Bulletin Expense	9,573
	$ 70,594

Expenses: Library	
Salaries & Wages	$ 20,363
Overhead	9,759
Books and Periodicals	11,133
Photoduplication	1,301
Binding	1,725
Medical Library Center of N.Y.	2,000
	$ 46,281
Total Expenses	$116,875

The Academy of Medicine is completing one of its most successful educational years. A total of 57 meetings was held, visiting more communities and reaching more physicians than ever before. These programs were presented in 36 communities in 16 counties, as well as New York City. 57 per cent were held outside of the metropolitan area.

Major Symposia & Courses	12
Roving Symposia	24
Section Meetings	21
	57

Major Symposia

A record number of 10 major symposia were presented this year with greater success than ever before. There has been a trend for some sections to present one large symposium, rather than holding 2 or 3 smaller meetings. This has resulted in more sophisticated speakers reaching a much larger audience.

Due to increased publicity, attendance at these meetings has almost doubled. Average attendance has reached 120 per meeting, with a high of 275 for one meeting.

Roving Symposia

The Roving Symposia continue to reach physicians practicing in the smaller communities of the State. A new and well received innovation has been the presentation of programs in four locations simultaneously, through Telelecture. With audio-visual material duplicated at each location, and two-way voice hook-up, these have been very successful.

Section Meetings

The sections continue to reach a small, select audience with exceptionally fine speakers. However, there has been a strong tendency in recent months to plan larger meetings and publicize them to all physicians in the area, rather than to just members of the sections.

Approved with the following notation: That the Academy be complimented on its work on the roving symposia and section meetings, and that the good work be continued **(page 412)**

AID Program

(Reference Committee "C")

Representatives of the New Jersey Blue Cross Plan are in the process of visiting each hospital in New Jersey to see how the AID Program is being implemented and to be of assistance in setting up procedures toward getting optimum results from the AID Program.

Of 68 hospitals reported thus far 52, or 76 per cent, have a procedure for implementing the AID Program to enable timely certification by the physician of need for continued stay; 16 hospitals or 24 per cent either have no procedure for timely certification or are not implementing the program except after discharge of the patient or on request for a certification by the Plan. The following data is of interest in comparing the two groups:

Table A	*Procedure for Timely Certification*	*No Procedure for Timely Certification*	*Total Reported*
Number of hospitals	52	16	68
Per cent of such hospitals	76	24	100
Number of beds	11,854	4,511	16,365
Per cent of beds	72	28	100
Census	10,478	4,127	14,605
Per cent occupancy	88.4	91.5	89.2
Total admissions (all patients)	408,293	155,884	564,177
Per cent total admissions	72	28	100
Average length of stay — total admissions	9.4	9.7	9.5
N.J. Blue Cross cases only	150,279	43,463	193,742
Per cent of N.J. Blue Cross cases only	78	22	100
Average length of stay — N.J. Blue Cross only	7.3	7.9	7.5
Per cent of N.J. Blue Cross cases to total admissions	37	28	34

It is interesting to note that those hospitals which implement the AID Program to permit timely certification by the physician have:

1. A lower occupancy rate.

2. A lower average length of stay — 0.3 days less for all patients and 0.6 days less for New Jersey Blue Cross patients.

The following translates the percentile savings indicated in Table A into dollar values:

Table A — Procedure for Timely Certification

Total Admissions		408,293
Difference in LOS		.3
Estimated Days Saved		122,487
1968 Estimated Average Per Diem		$ 60.35
		$7,392,090
Blue Cross Admissions		150,279
Difference in LOS		.6
Estimated Days Saved		90,167
1968 Estimated Average Per Diem		$ 60.35
		$5,441,578

Blue Cross Cases Paid in 1968 — N.J. Contracting Hospitals

Total Cases	271,459	
Hospitals Surveyed 68 (Table A)	193,742	
	77,717	
*Timely Certification	77.6%	
	60,277	Cases
Estimated Days Saved @ .6 (Table A)	36,166	
1968 Estimated Average Per Diem	$ 60.35	
	$2,182,618	
1968 Total Estimated Savings	$7,624,196	

*Based on Relationship of 150,279 to 193,742 (Table A)

While many variables are involved, the implementation of the AID Program may be credited to a considerable degree for the differences.

Another phase of the review by Plan representatives dealt with whether the certification forms are being sent to the utilization review committee. Table B reveals the data for 52 hospitals which were implementing the AID Program for timely certification; the 16 hospitals which were not, are excluded since none of them referred the certifications to their utilization review committees.

Table B	*Refer Certifications to Utilization Committee*	*Do Not Refer Certifications to Utilization Committee*	*Total*
Number of hospitals	38	14	52
Per cent of such hospitals	73	27	100
Number of beds	9,245	2,609	11,854
Per cent of beds	78	22	100
Census	7,892	2,586	10,478
Per cent occupancy	85.4	99.1	88.4
Total admissions (all patients)	309,254	99,039	408,293
Per cent total admissions	76	24	100
Average length of stay — total admissions	9.3	9.6	9.4
N.J. Blue Cross cases only	119,258	31,021	150,279
Per cent of N.J. Blue Cross cases only	79	21	100
Average length of stay — N.J. Blue Cross only	7.3	7.6	7.3
Per cent of N.J. Blue Cross cases to total admissions	39	31	37

It is interesting to note that those hospitals which refer the certification forms to the utilization review committee have:

1. A lower occupancy rate.

2. A lower average length of stay — 0.3 days less for all patients and for Blue Cross patients.

While many variables are involved the referral of certifications to the utilization committee may be credited partially for the differences.

Conclusion

Although many variables are involved in study of length of stay, in evaluating the effectiveness of the AID Program the evidence seems to be preponderantly for the conclusion that it is an effective tool in the reduction of unnecessary length of stay even though its optimum results have not been achieved. Continued efforts should be made to improve its implementation with the expectation of improved results.

Approved **(page 413)**

Supplemental Report #2

The Board of Trustees held its final meeting for the fiscal year 1968-69 on Friday evening, 16 May. The following items from that meeting are directed to the attention of the House.

Relief of Widows and Orphans of Medical Men

(Reference Committee "H")

The Board was reacquainted with the aims and purposes of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey. The President of the Society reported to the Board that the affairs of his organization are in good order. Membership has reached a new high of 1,088 members and 20 applications for membership are being processed. The death benefit has attained a new high of $1,100. Dr. Herbert A. Schulte and Dr. Joseph W. Gardam have retired from their posts. Dr. Ogden B. Carter, Jr. has been elected Custodian of the Permanent Fund and Dr. John Kengeter has been elected Secretary. The Board reaffirmed its support of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey.

Approved with commendation to the Officers of the Society for their dedicated services **(page 426)**

Resolutions #7 and #8 of the 1968 House

(Reference Committee "E")

Resolution #7, adopted by the 1968 House, urged that The Medical Society of New Jersey petition the State Department of Institutions and Agencies to establish the principle throughout New Jersey that diagnostic, laboratory, and medical specialty services be allowed when found necessary by the treating physician, and that payment for such services be on a realistic, reasonable, and customary fee basis.

Resolution #8, adopted by the 1968 House, directed that The Medical Society of New Jersey petition the New Jersey Department of Institutions and Agencies to bring the physicians fees for services paid by all welfare boards in the state up to a realistic level on a reasonable and customary fee basis.

Both resolutions further resolved that the Society deal directly with the Department of Institutions and Agencies to embody these principles in their present and future plans, ". . . so that there will be no mistake of our intent or resolve and so that these tenets be effected by May 1969."

The Society has through the year emphasized and urged the effectuation of these resolutions with the Department of Institutions and Agencies. The most recent utterance by the Department in this connection was contained in a letter dated 14 May 1969, addressed to the Secretary of The Medical Society of New Jersey's Board of Trustees by Lloyd W. McCorkle, Commissioner of Institutions and Agencies.

Commissioner McCorkle states:

". . . the major development which has occurred during the last year, that is relevant to Resolutions #7 and #8 of your Society, was the enactment of Chapter 413 of the Laws of 1968, generally referred to as 'Medicaid,' which will become operational 1 January 1970.

Under this law, the County Welfare Boards, and the State Division of Public Welfare as well, will be relieved of authority and responsibility for regulating the amount, kind, and rates of allowances for all elements of medical and paramedical care furnished to welfare recipients by any facility or practitioner. The new program will be administered on a uniform statewide basis by a new Division of Medical Assistance and Health Services established within this Department.

The specific recommendations contained in the resolutions referred to, as well as many others of similar concern to your Society, will be deliberated in the course of the next few months by the Medical Advisory Council and the various subsidiary technical Advisory Committees which are now in the process of being created as part of the organizational structure for implementing the Medicaid program."

Approved (page 417)



Reorganization Meeting 1969-1970 Board of Trustees

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton

(Reference Committee "A")

From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from 1 April 1968 through 31 March 1969:

By Judicial Committees

Complaints reported as disposed of	58
Alleging:	
Dissatisfaction concerning fees	54
Unethical conduct	3
Dissatisfaction with services rendered	9
Unprofessional conduct	19

By the Judicial Council

Meetings held	8
Official communications acted upon	15
Appeal hearings requested	7
Appeal hearings granted	1
Formal opinions rendered	4

(1) The ethical acceptability of adding the collection agency charge to delinquent accounts

(2) The ethical acceptability of credit card payment to physicians for medical services rendered

(3) The ethical acceptability of a new billing procedure at a community hospital

(4) The ethical acceptability of a physician, such as an anesthesiologist, who does not require office space, placing his billing service with a collection agency and on his letterhead using his name, but the agency's address

The foregoing opinions are presented in full as an appendix to this report.

Analysis of the types of complaints presented against our member-physicians indicates a substantial increase in the number of those alleging "dissatisfaction concerning fees." We again stress the fact that, wherever possible, it is wise and desirable that a clear understanding be arrived at between physician and patient regarding this matter, before treatment is undertaken.

Conference with Chairmen of Component Committees

In November the Council held a conference with the chairmen of the judicial committees of component societies, at which copies of the newly revised "Regulations" were distributed and discussed, and questions were answered covering all aspects of the judicial mechanism. The purpose of the conference was the achievement of a better understanding of, and increased efficiency in, the operation of the Society's statewide judicial mechanism. Of the 21 counties, 18 sent a representative to the conference.

Conference on Medical Ethics

By designation of the Board of Trustees, the chairman attended the Second National Congress on Medical Ethics held in Chicago on 5-6 October 1968.

Medicare Complaints Involving Fee Disputes

(Reference Committee "E")

At the request of the Board of Trustees, the Council advised all chairmen of judicial committees and secretaries/executive secretaries of component societies of the following Board-approved (February 1969) recommendation of the Council on Medical Services:

When the Medicare carrier, afer due consultation with its medical advisors, feels a question of professional conduct or ethical deportment is at issue, it be advised to process its complaint through the judicial mechanism as the proper agency under the Bylaws of MSNJ (Chapter VII).

The Judicial Council called for the cooperation of all interested agencies, societies, and members in implementing the foregoing directive.

Resignation of E. Vernon Davis, M.D.

Having been elected second vice-president of The Medical Society of New Jersey in May 1968, E. Vernon Davis, M.D. resigned from his position as Chairman of the Judicial Council. The House appointed I. Edward Ornaf, M.D. to replace him as fourth district councilor to complete Dr. Davis' unexpired term.

Opinion #1

Ethical acceptability of adding the collection agency charge to delinquent accounts

Directed to the Council's attention was an inquiry made by a component medical society as to whether or not a collection charge — assessed physicians for collection of delinquent accounts by collection agencies — could ethically be added to the physician's bill owed, thereby enabling him to collect for his professional services in full. This procedure would be explained to patients before relinquishing their accounts for collection.

It was the unanimous opinion of the Judicial Council that the adding of a collection agency fee to delinquent accounts would be unethical. To support this opinion, the Judicial Council cited Section 7 of the Principles of Ethics of the American Medical Association (to which principles members of The Medical Society of New Jersey also subscribe):

> In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Opinion #2

Ethical acceptability of credit card payment to physicians for medical services rendered

In answer to this inquiry, the Council cited Section 7 of the Principles of Medical Ethics of the American Medical Association:

> In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay . . .

The Judicial Council of the American Medical Association has issued several dicta relative to this matter. In 1962 it declared:

> Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable.
>
> It is not in the best interest of the public or the profession to charge a penalty if fees for professional services are not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

In added reference, in November 1966, the Judicial Council of the AMA issued an opinion which in part declared:

> The Judicial Council is of the opinion that neither endorsement nor disapproval should be given to the bank card system at this time.
>
> In June 1965, the Judicial Council and the Council on Medical Services jointly agreed that any proposed plan for financing medical care or parts of medical care should be judged by the physician in the light of whether or not it might "result in advertising or solicitation of patients by physicians, profit to physicians for other than professional services, exploitation of the patient, or unnecessary increase in the cost of medical care."
>
> Judged by these criteria, the Judicial Council is of the opinion, at this time, that physician participation in bank card programs is not per se unethical. It is of the opinion that physicians may ethically accept bank cards in the payment of current medical bills in lieu of cash or check, that is, as a medium of exchange.
>
> The use of bank cards in financing medical fees must, however, be viewed with reserve at the present stage of their development. While patients may not be denied the right to determine matters of their personal budgeting, physicians must not encourage the use of this financing method if in operation it might compromise the ideals of the medical profession or add to the financial burden of patients.
>
> In connection with physician participation in bank card programs, the Judicial Council recommends the following principles to be implemented and applied as necessary by the county medical society for the guidances of physicians as these programs develop.
>
> 1. The county medical society should be satisfied as to the financial and professional integrity of the plan. It should negotiate with the plan sponsors to insure that service charges to the physician are reasonable. It should insist that the plan be open to all physicians on the same terms that it not exploit or capitalize on physicians' participation in the plan. It should advise the plan that the listing of physicians in directories of participating members is contrary to the ethics of the medical profession.

2. The individual physician may not, because of his participation, increase his fee for medical service rendered the patient. He may not use the plan to solicit patients. He may not encourage patients to use the plan. His position must be that he accepts the plan as a convenience to patients who desire to use it. Plaques or other devices indicating participation in the plan within the physician's office shall be kept to a discreet and dignified minimum. Plaques, signs, or other devices indicating such participation visible outside the physician's office are unacceptable.

3. The use of a bank card in connection with the payment of larger fees — which might normally be paid to the physician in installments — is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges. Out of respect for the dignity and traditions of the medical profession, the physician may not relieve himself of his obligations "to render service to humanity, reward or financial gain being a subordinate consideration."

The Judicial Council of The Medical Society of New Jersey subscribes to and supports these statements of the Judicial Council of the American Medical Association.

Opinion #3

Ethical acceptability of a new billing procedure proposed at a community hospital

The Council considered a letter from an officer of a component society requesting an opinion concerning a new billing procedure proposed by a local hospital, in conjunction with the processing of Papanicolaou smears.

The Council cited as relevant and governing the following excerpts taken from Section 7 of the American Medical Association's Judicial Council Opinions and Reports:

Billing Procedure for Laboratory Service

The Council discussed the propriety of a physician charging patients for laboratory tests, performed by someone else, in excess of the cost to him. Some doctors justify the charge on the basis that they interpret the reports and assume the responsibility for the correctness of the reports.

It was agreed by the members of the Council that a physician's bill should truly reflect the basis of his charges. Thus, the physician's bill should indicate the actual cost of the laboratory report to him but, at the same time a physician might include a separate charge for his interpretation of the report. In this regard the Council adopted the following statement:

"The billing to a patient should truly reflect the charges made for analytical services and those for professional services." (1963)

1. The practice of pathology is an integral part of the practice of medicine,

2. All physicians should bill their patients directly, and

3. In exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services. (1965)

In light of the foregoing, the Council directed that the officer-member be informed that the Judicial Council of The Medical Society of New Jersey finds nothing unethical, as regards participation by staff members, in the hospital's planned procedure, provided that the exactions set down by the Judicial Council of the American Medical Association are observed.

The Council further noted that it has jurisdiction only over members of The Medical Society of New Jersey and is without authority to judge the ethicality of a hospital's actions.

Opinion #4

Ethical acceptability of a physician, such as an anesthesiologist, who does not require office space, placing his billing service with a collection agency and on his letterhead using his name, but the agency's address

The Judicial Council considered a letter from the chairman of the judicial committee of a component society asking the Council: "Is it proper for a physician who does not require office space, such as an anesthesiologist, to place his billing service with a collection agency and, for his letterhead use his name but the agency's address?"

After much discussion, the Council authorized the following comment:

The Judicial Council of the American Medical Association has been seriously concerned with billing practices utilizing collection agencies. The members of the Judicial Council of The Medical Society of New Jersey agree with the AMA Judicial Council that such a procedure is neither professional nor becoming to physicians. It misleads patients and does not permit a patient who has received a bill bearing such an address

to contact the physician without going through the collection agency. A third party not steeped in the traditions of medical practice enters in the physician-patient relationship.

The Judicial Council of The Medical Society of New Jersey concurs in the sentiments expressed by the AMA Judicial Council in 1962:

Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable.

The Judicial Council offers the following statement of the AMA Judicial Council (November 1968) as relevant:

In referring any account to a collection agency, the physician should first give due consideration to the patient's ability to pay the fee which is due. Secondly, the physician should not utilize the services of a collection agency whose tactics and methods of collection might bring the medical profession into disrepute. The physician may not "sell" his delinquent accounts to a collection agency and may not enter into any arrangement under which the physician would lose complete control of the delinquent account or the method of its collection.

For the aforementioned reasons, the Judicial Council is of the opinion that the questioned practice is not ethically acceptable.

Approved **(page 409)**

Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")

In reporting upon my first full administrative year of service to the Society in 1952, I said, "Time spent in activities that are interesting and absorbingly worthwhile is always swift in its flight." Now as I address myself to the composition of my nineteenth annual report I realize that when I made that statement I uttered a truth more penetrating than I knew, because not only are our activities interesting and absorbingly worthwhile but they are constantly expanding in number and range, and time is always in short supply.

One indication of our expanding activities is the growing bulk of the annual reports. They are not compiled with any sly purpose of burdening the members of the House of Delegates but only in the hope of informing them adequately concerning our work as an organizaton.

I have little to mention that is not already covered in other reports before the House. The record demonstrates that the Board of Trustees and all the councils and committees of the Society assiduously and energetically dealt with a host of concerns vital for the protection of the interests of our members and the public to whose welfare they are all dedicated.

As our president, Doctor Kustrup gave himself unstintingly to the demands of his office, setting an example which his fellow officers and Board members splendidly followed. Through his appearances at public and committee hearings and the thoughtful statements that he made, the Society's policies and thinking have been regularly and clearly set forth. Whether they will consistently prevail only the future will disclose.

There is basis for hope that our official thinking is constructively considered in the fact that our efforts in the area of State legislation this year were in important instances successful. For example, three bills that we caused to be introduced and that we actively supported were enacted — those granting confidentiality to patient-physician communications, permitting physicians to treat minors for venereal disease without parental consent,

and authorizing any licensed physician to examine minors applying for working papers. Again, the pocket veto by the Governor of two bills to give chiropractors equal status under health insurance coverages with fully licensed physicians was what we had urged. Some credit must here be given to HEW Secretary Wilbur J. Cohen's timely report to the Congress on "Independent Practitioners Under Medicare", copy of which we were able to forward to the office of the Governor about three weeks prior to his decision on the chiropractic measures.

It is a pleasure to report that the members of our staff matched the diligence and high competence of our officers and council and committee members. Mr. Vincent A. Maressa, my Executive Assistant, was admitted to the New Jersey Bar last spring, so through the year we have had the benefit not only of his expert knowledge and assistance in the conduct of Society operations, but also of his ready and able day-to-day advice on legal questions addressed by our members to us. Mr. E. Powers Mincher has rendered yeoman's service in his dual capacity as Acting Legal Counsel and Legislative Analyst. What is true of these two gentlemen is true of every member of our staff. They are devoted, able, reliable, and amiable, and I am proud and happy to work with them for The Medical Society of New Jersey.

My basic duties are as chief of that staff — guiding and encouraging them and being guided and encouraged by them, in turn. In the course of the year, I logged participation in 173 meetings and conferences, made 16 visits to component societies, journeyed to 3 out-of-state meetings (all AMA sponsored), and made 14 speech presentations.

There can be no challenge to the statement that we live in changeful, troubled, and distressed times. Whatever we do, we can expect to be critically scrutinized and not infrequently condemned. There should be solace and encouragement for us, however, in the realization that no assault from without can avail against the abiding vitality of combined integrity, intelligence, and good will within. Enlightened and high-souled competence has little to fear from the threats of hostile mediocrity. It is our task to preserve the strength and integrity we have, and to add to it by the merits of our constructive efforts through each succeeding day. We of medicine must not be content to fight a defensive battle. As against disease and death, our strategy is attack — attack against the very strongholds of our opposition — by a forthright avowal of and an uncompromising devotion to the ideals and principles of community life and service which have made Medicine the most exalted and beloved of professions, and which alone can preserve it as such.

Approved (page 409)

1968 TRANSACTIONS

At its first session on Saturday, 17 May 1969, the House of Delegates approved, as corrected, the Transactions of the 1968 House of Delegates as published in the July 1968 issue of THE JOURNAL and distributed to the membership. The error appears in Supplemental Report #2 of the Council on Legislation, page 338. The action concerning S-655 should read:

"DISAPPROVED, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program."

Annual Meeting

Jerome G. Kaufman, M.D., Chairman, Maplewood

(Reference Committee "H")

The committee met in July and again in September to formulate plans for the 203rd annual meeting, in accordance with directives of the 1968 House of Delegates and of the Board of Trustees.

In order to expedite the business of the 1969 House of Delegates, official guests to the convention will be allowed a three-minute presentation at the opening session only. Anyone present at a subsequent session will be introduced from the floor without time for comment. The third session of the 1969 House will begin promptly at 9:00 a.m.; it will be limited exclusively to the work of the House.

Reference committee reports will be made available in advance of distribution to the House to members of the reference committees and to *one* officially designated representative of each component society.

The final meeting of the 1968-69 Board of Trustees will be held in the Bakewell Room at 4:00 p.m., Friday afternoon. In order to accommodate the increased number of Board members, the reorganization meeting will be held in the Derbyshire Room at 8:30 a.m., Wednesday morning.

An additional room adjoining the Officers' Hospitality Parlor will be reserved in 1969 for the comfort of invited guests and for the private discussion of business of the convention. A detailed outline of the duties, responsibilities, and time assignments will be made available in advance to the co-hosts of the Hospitality Parlor.

Past experience and attendance records have shown that the majority of registrants leave Atlantic City immediately following the last session of the House on Tuesday afternoon. Therefore, in an effort to improve attendance at the scientific sessions and the exhibits, the following schedule has been set up for 1969:

Registration will open at 9:00 a.m. on Saturday, and close at 5:00 p.m. on Tuesday;

Exhibits will open at 10:00 a.m. on Sunday, and close at 5:00 p.m. on Tuesday;

MSNJ scientific sessions will be held on Monday and Tuesday mornings and afternoons;

The New Jersey State Department of Institutions and Agencies will sponsor an off-Broadway production on Saturday evening at 9:00 p.m.;

The Academy of Medicine of New Jersey will present a special session on Sunday morning at 9:30 a.m.

The 1969 House of Delegates will meet on Saturday, Sunday, and Tuesday. The meeting of the Nominating Committee is scheduled for 4:30 p.m. on Saturday. Dr. Henry A. Davidson, Editor of *The Journal* accepted appointment to serve as Parliamentarian for 1969. The Golden Merit Award Ceremony will precede the first session of the House, and the Open Discussion on Medical-Surgical Plan will follow that session. A General Session on the New Jersey Medicaid Program will immediately follow the inauguration of the incoming President. Commissioner McCorkle of the New Jersey State Department of Institutions and Agencies will be the speaker.

All registered members and official guests will be invited to attend the Inaugural Reception on Sunday evening. Because of the change in exhibit hours, the Reception-Buffet Dinner for technical exhibitors will be held on Sunday evening following the Inaugural Reception. The invitation list will include technical exhibitors, Trustees and Officers; tickets will be on sale to anyone else wishing to attend. The Annual Dinner-Dance, honoring the President, is scheduled for Monday evening.

The advance program was mailed in early February to the membership, all invited speakers and guests, non-member exhibitors, and editors of journals of nearby state medical societies. The April issue of *The Journal* will carry the detailed day-by-day outline of the

annual meeting, including abstracts of the scientific session presentations. The final program will be distributed to all who register in Atlantic City.

Thirty-four scientific exhibits and fourteen informational exhibits will be presented this year.

In addition to the Coffee Lounge, which will be sponsored by the Prudential Insurance Company of America, and the Message Center, to be "manned" by members of the New Jersey Medical Assistants Association, Inc., forty-seven technical exhibits will be featured.

Each year there is a noticeable decline in requests for technical exhibit space. This year, in lieu of purchasing exhibit space, generous contributions were received from several pharmaceutical houses. The Board approved a recommendation of the committee that these contributions be accepted and stipulated that the money be ear-marked and identified for specific educational purposes.

It was generally agreed that the attendance awards presented at the 1968 annual meeting did little to improve the flow of traffic through the exhibits; therefore, the awards will be discontinued in 1969.

The committee wishes to stress the importance of visiting the exhibits. The monies derived from the sale of booth space are the only source of revenue whereby annual meeting expenses can be met. Everyone in attendance at the annual meeting is urged to support our exhibitors and visit the exhibits.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

204th annual meeting — Saturday-Wednesday, May 16-20, 1970

205th annual meetng — Saturday-Wednesday, May 15-19, 1971

206th annual meeting — Saturday-Wednesday, May 13-17, 1972

Recommendation

That the 207th annual meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Wednesday, May 12-16, 1973.

Approved with notations (page 426)

Scientific Exhibits*

Milton Ackerman, M.D., Chairman, Atlantic City

(Reference Committee "H")

This subcommittee, under the chairmanship of Milton Ackerman, M.D., took the following actions during the year:

1) The Committee made several minor revisions on the application form for space in the scientific exhibits. Forms were then distributed to Medical Directors of all New Jersey, New York City, and Philadelphia hospitals; to Deans and Chairmen of Departments of Instruction of all New Jersey, New York City, and Philadelphia medical schools; to the New Jersey State Departments of Health and of Institutions and Agencies; and to Speakers on the 1969 Programs of the Scientific Sections.

2) The committee also supplied the editors of *The Journal* and of the *Membership News Letter with* copies of the application, with the request that they print items calling attention to and urging the members of the Society to participate in the 1969 Scientific Exhibits. A copy of the application form was inserted as a tear sheet in the November and December issues of *The Journal.*

* Subcommittee of Annual Meeting Committee

3) The committee agreed to provide space at the 1969 meeting for Informational Exhibits offered only by committees of MSNJ and those organizations which are classified as cooperating agencies with MSNJ.

4) The committee revised the floor plan for the exhibit hall, as requested by the Committee on Annual Meeting and as approved by the Board of Trustees.

5) The committee obtained a sponsor, and selected and scheduled suitable films, for the Motion Picture Theatre.

6) The committee selected suitable exhibits in the Scientific and Informational categories from the applications submitted.

7) The committee revised the Awards presentation to accommodate the withdrawal of the Mead Johnson Aesculapius Award. The committee agreed to award two MSNJ plaques to the first and second place scientific exhibits and not more than five honorable mention certificates to other scientific exhibits of merit selected by the Awards Committee.

Approved with notations (page 426)

Scientific Program*

James A. Rogers, M.D., Chairman, Paterson
(Reference Committee "H")

Under the chairmanship of James A. Rogers, M.D., the Officers of the Scientific Sections met on two different occasions with the Committee on Annual Meeting.

All of the twenty-one scientific sections will meet in 1969 — either singly or in combined session — and the following schedule was agreed upon:

Monday morning, May 19, 1969

Joint Session on Allergy, Metabolism
Joint Session on Chest Diseases, Clinical Pathology
Joint Session on Obstetrics and Gynecology, Radiology
Session on Orthopedic Surgery, co-sponsored by the New Jersey Orthopaedic Society
Session on Otolaryngology

Monday afternoon, May 19, 1969

Joint Session on Anesthesiology, Pediatrics, Urology
Session on Ophthalmology
Session on Psychiatry and Neurology
Session on Rheumatism
Session on Surgery

Tuesday morning, May 20, 1969

Session on Cardiovascular Diseases
Joint Session on Gastroenterology and Proctology, General Practice

Tuesday afternoon, May 20, 1969

Joint Session on Dermatology, Medicine
Session on Plastic and Reconstructive Surgery

The chairman requested that all section officers give primary consideration to the many outstanding members whom MSNJ has to offer as opposed to inviting an overabundance of out-of-state speakers. A total of sixty speakers will participate in the fourteen scientific programs.

On Saturday evening at 9:00 p.m., the New Jersey State Department of Institutions and Agencies will present "The Concept," an off-Broadway play dealing with the therapeutic community treatment of ex-narcotics addicts.

The Academy of Medicine of New Jersey will sponsor a special Symposium on Factors Leading to the Diagnosis of Life and Death. This session is scheduled for Sunday morning.

Approved with the following notations: A suggestion to have separate legislative and scientific meetings; a proposal to encourage specialty groups to combine their separate annual meetings under the aegis of the scientific sessions of The Medical Society of New Jersey, with each specialty formulating its program to stimulate maximum attendance by its members. The Reference Committee suggested (and the House concurred) that the aforementioned notations be referred to the Board of Trustees. (page 426)

* Subcommittee of Annual Meeting Committee

Credentials

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period 1 April 1968 to 31 March 1969.

The Committee again expresses appreciation to the officers of component societies for their cooperation.

Approved (page 409)

	Associate	*Advancement to Active*	*Active*	*Total*
Received	368	244	47	659
Reviewed and found:				
Satisfactory	294	227	41	562
Unsatisfactory	34*	0	0	34
Pending	40	17	6	63
Total	368	244	47	659

* Non-citizens, not eligible for election to membership pending action of 1969 House of Delegates on modification of the MSNJ Bylaw requiring actual citizenship as a qualification for membership

Honorary Membership

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg

(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were held during this administrative year.

Approved (page 426)

Finance and Budget

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal

The anticipated *Journal* Deficit has increased, for the first time in five years. This can be attributed to several factors: (1) the sharp decline of the volume of advertising supplied by SMJAB; while local advertising income has remained stable; (2) the effects of the new rate structure reflecting a 10 per cent increase for full page advertisements and a 5 per cent increase for one-half page advertisements, although effective 1 July 1968 did not achieve full impact until 1 January, 1969 upon renewal of expiring contracts; (3) and another increase in production cost as of April 1969. However, this trend is consistent within the printing industry, and it is felt that Periodical Press has rendered another satisfactory year as printer of *The Journal.*

The anticipated deficit for publication of *The Journal,* Journal Salaries and salary taxes (including those of the editor and assistant editor), Journal office expenses and travel, editor's insurance, and other Journal expenses will be charged off to the unexpended balance in the 1968-69 budget accounts at the end of this fiscal year. A net surplus will still result in the 1968-69 total budget.

Your Committee has approved, with the concurrence of the Board of Trustees, the establishment of a Journal Deficit Reserve Account to offset any future deficit when there may not be sufficient unexpended surplus to absorb a *Journal* Deficit.

Fiscal Year Versus Calendar Year

The 1968 House of Delegates referred to your Committee Resolution #29 — Amendment to Bylaws Re Fiscal Year — for further study and report to the 1969 House of Delegates.

After detailed study, your Committee recommends, with concurrence of the Board of Trustees, that the fiscal year of the Society remain unchanged (first day of June through the thirty-first day of May), with the audit report, budget estimates, and appropriations extending for the same period.

Your Committee further recommends, with concurrence of the Board of Trustees, that upon completion of the Annual Audit and the meeting of the Audit Committee, a copy of both the audit report and the minutes of the Audit Committee meeting, together with the Board action thereon, be furnished to each Component Society of The Medical Society of New Jersey.

1970 Assessment

The computation of cash surplus at the close of the current fiscal year is estimated at $234,604.81 — 56.4 per cent above the $150,000.00 sum which has been indicated as the desired minimal surplus amount at the beginning of each new fiscal year.

In accordance with Chapter X of the Bylaws, the dues year is 1 January to 31 December, and the fiscal year is 1 June to 31 May. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1969 and 1970 per capita assessment to the 1969-70 fiscal year on the basis of 7/12 of the 1969 assessment for the new fiscal year soon to commence (1 June 1969) and 5/12 of the 1970 assessment for the latter part of that fiscal year starting 1 January 1970.

The following is the Computation of Cash Surplus and the Determination of the 1970 Assessment:

Proposed budget for 1969-70	$373,576.00
7/12 of 1969 assessment applicable to 1969-70 budget	192,032.60
Amount to be raised by 5/12 of 1970 assessment	$181,543.40
$67.00 × 6,504 members paid = $435,768.00 × 5/12	$181,570.00
Amount to be raised with surplus over $150,000.00 applied to budget excess at 5/31/69, estimated	$ 84,604.81
Amount needed to reduce the per capita assessment from $67.00 to $55.00	32,520.00
Remainder of surplus in excess of $150,000.00	$ 52,084.81
Add the required surplus	150,000.00
Estimated adjusted cash surplus at 5/31/69	$202,084.81
$55.00 × 6,504 members paid = $357,720.00 × 5/12	$149,050.00
plus the amount raised from surplus	32,520.00
Amount to be raised to meet 5/12 requirement	$181,570.00

For each $1,000.00 increase in the proposed budget add 37 cents to assessment. For each $1,000.00 decrease in the proposed budget, subtract 37 cents from assessment.

1969-70 Budget

The proposed budget for 1969-70 totals $373,576.00. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Recommendations

1) That the budget for 1969-70 be adopted in the total sum of $373,576.00.

2) That the 1970 assessment be adopted at $55.00 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor.

3) That the House of Delegates approve the recommendation that the fiscal year of the Society remain unchanged (first day of June through the thirty-first day of May), with the audit report, budget estimates, and appropriations extending for the same period.

4) That the House of Delegates approve the furnishing of copy of the audit report, the minutes of the Audit Committee meeting, and the Board action thereon to each Component Society of The Medical Society of New Jersey.

ACCOUNT	CURRENT 1968-69 BUDGET	FOOT-NOTES	PROPOSED 1969-70 BUDGET
A — 1 — Executive Salaries	$ 58,597.00	(1)	$ 61,270.40
A — 2 — General Staff Salaries	94,351.00	(1)	103,919.97
A — 3 — General Exec. Office Expenses	15,000.00	(2)	16,000.00
A — 4 — Executive Travel	3,300.00	(3)	3,000.00
A — 5 — House Maintenance	17,800.00	(4)	19,000.00
A — 6 — Treasurer	5,700.00	(5)	5,800.00
A — 7 — Finance & Budget	75.00		75.00
A — 8 — Secretary	450.00		450.00
A — 9 — Salary Taxes	6,890.00	(6)	7,290.63
A — 10 — Insurance	8,450.00	(7)	8,810.00
A — 11 — House Reserve	5,300.00	(8)	6,600.00
C — 2 — Legislation	4,200.00	(9)	8,800.00
C — 3 — Public Health	2,500.00	(10)	2,650.00
C — 4 — Public Relations	6,750.00	(11)	6,800.00
C — 5 — Medical Services	700.00		700.00
C — 6 — Mental Health	1,350.00	(12)	1,450.00

ACCOUNT	CURRENT 1968-69 BUDGET	FOOT-NOTES	PROPOSED 1969-70 BUDGET
D — 1 — President-Pres. Off.	10,590.00	(13)	14,960.00
D — 2 — AMA Delegates	11,060.00	(3)	8,400.00
D — 3 — Woman's Auxiliary	5,925.00	(14)	3,175.00
D — 4 — Medical Education	150.00	(15)	35,150.00
D — 5 — Conference Groups	500.00		500.00
D — 6 — Membership Directory	14,753.00	(16)	15,000.00
D — 7 — Emergency Medical Care	325.00		325.00
D — 8 — Credentials & Membership	250.00	(17)	350.00
D — 9 — Archives & History	100.00		100.00
D — 10 — Project Hope-Vietnam	6,000.00		6,000.00
D — 11 — Med. Def. & Insurance	500.00		500.00
E — 1 — Board of Trustees	5,900.00	(11)	6,150.00
E — 2 — Contingent	10,000.00		10,000.00
E — 3 — Judicial Council	500.00	(18)	550.00
E — 4 — Legal	5,300.00	(19)	6,300.00
E — 5 — Health Facilities Planning Council	———	(20)	5,000.00
E — 6 — Medical Student Loan Fund	13,000.00	(21)	5,000.00
E — 7 — Authorized Reimbursement for Representatives to Meetings	———	(22)	3,500.00
TOTALS	$316,266.00		$373,576.00

FOOTNOTES FOR BUDGET

(1)—Increase due to merited increments to both executive and general personnel.

(2)—Increase due to higher office service expenses.

(3)—Decrease due to AMA Annual Meeting in New York, and Clinical Meeting in Denver, Colorado.

(4)—Increase due to higher house maintenance expenses which includes executive office property taxes.

(5)—Increase due to higher cost expected in this account.

(6)—Increase due to higher salary taxes resulting from increased staff salaries.

(7)—Increase due to anticipated premium increase in Hospital Service Plan Coverage.

(8)—Increase due to anticipated purchase of new office equipment.

(9)—Increase due to the retainment of a legislative consultant and the appointment of two official legislative educational representatives.

(10)—Increase due to enlarged Eye Health Screening Program for 1969.

(11)—Increase due to higher specific cost — supplies and postage — charged to this account.

(12)—Increase due to higher exhibit cost anticipated for the 1970 Annual Meeting.

(13)—Increase due to a higher allowance provided to each Society President as reimbursement for the loss of twenty-five percent of professional income in consequence of his performance of presidential duties.

(14)—Decrease due to AMA Annual Woman's Auxiliary meeting in New York.

(15)—Increase due to 1968 House of Delegates' mandate to provide an amount in this account equivalent to a $5.00 special per capita assessment.

(16)—Increase due to cover pending plan to publish a list of "Errata," to the *Membership Directory*, 1968-69 edition.

(17)—Increase due to anticipation of modifying the membership application form.

(18)—Increase due to expected higher travel reimbursement.

(19)—Increase due to increment granted legal counsel.

(20)—The 1968 House of Delegates approved the establishment of the — Health Facilities Planning Council — a separate budgetary account.

(21)—Decrease due to a lower immediate demand for funds for MSLF loans.

(22)—The 1968 House of Delegates approved the establishment of the — Authorized Reimbursement for Representatives to Meetings — a separate budgetary account to relieve the Contingent Account (E-2) of these specific charges.

Approved with the suggestion that the procedure of supplying copies of the budget to the members of the reference committee ten days in advance of the Annual Meeting be continued **(page 412)**

Medical Defense and Insurance

Fred A. Mettler, M.D., Chairman, Blairstown

(Reference Committee "C")

At the close of the present year The Medical Society of New Jersey offered to its members, through its brokers, coverage of the following types in officially endorsed plans:

1. Basic and Extended Income Protection (Accident and Health)
2. Long Term Income Protection (Accident and Health)
3. Major Expense
4. Life
5. Accidental Death and Dismemberment
6. Professional Acts Liability Program
7. Professional Premises Liability
8. Personal Catastrophe (Excess Liability or Umbrella)

A synopsis of these, including rates, was issued to all members last November and may be obtained from the Executive Office of the Society.

Accident and Health Insurance

The Society's accident and health insurance program has just completed its 38th year of service to our members. This comprehensive disability income program affords a total monthly benefit of up to $2,200 a month during total disability due to injury or sickness. The program consists of two parts: the Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability the Basic plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65.

Basic-Extended Plan

The Basic disability plan provides as much as $1,200 monthly benefit with the National Casualty Company and the Nationwide Mutual Insurance Company basic programs, each providing $600 monthly benefit. Benefits are payable from the first day of accident total disability for as long as five years, and from the eighth day of sickness total disability for as long as two years. The plan also pays, at half the monthly benefit rate, from the first day of accident partial disability for as long as six months. The plan also includes accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime, and sickness total disability benefits may be extended for an additional five years, or a total of seven years altogether. Of our members, 3,687 hold the National Casualty Company basic policy and 2,830 hold the Nationwide Mutual Insurance Company basic policy.

Long-Term Professional Income Protection Plan

This plan, through the Nationwide Mutual Insurance Company, provides up to $1,000 monthly benefit in addition to the benefits provided under the Basic-Extended plan. Benefits are payable for lifetime for accident total disability and to age 65 for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to age where other financial arrangements begin to fall into place, such as annuities, life insurance settlement options, and social security. The plan also affords six months of accident partial disability at half the monthly benefit rate.

Benefits may begin from the first day of accident disability and from the eighth day of sickness disability (or the first day of hospital confinement, if earlier), or on the 15th, 31st, 61st, or 91st day of disability with appropriate reductions in premium. Currently, 465 members participate in this program which began in 1967. It is possible for a member to have the various disability plans in almost any combination of monthly benefit which fits his

requirements. The ideal goal for most physicians is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary, inasmuch as all benefits are tax free for Federal income tax purposes.

Members who apply for the Basic and Extended policies within their new member periods are issued coverage, within certain limits, without regard to medical history.

The Committee on Medical Defense and Insurance has just accepted an improvement in the accident and health insurance policies issued by the Nationwide Mutual Insurance Company. The improvement is in the form of a rider to be added to the Basic, Extended, and Long Term policies at no additional premium. Briefly, the new rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as those provided each insured member under the Society's program.

Major Expense Plan

Our Major Expense Plan provides up to $15,000 of benefit paying 80 per cent of covered expenses in excess of a $500 deductible. Of our members, 2,709 plus dependents are participating in this program at the present time. During 1968, $150,222.00 was paid to our members under this plan.

Hospital Daily Indemnity Policy

The rising cost of hospital care (with charge of $100/day already in sight), and the tendency to employ a wide variety of ancillary diagnostic and therapeutic services, are pressing hard against the rates we have been able to maintain thus far. Individual instances of lower cost coverage have been investigated, and we have had several requests to provide more extensive coverage in the major medical expense range. There are several reasons why it would be disadvantageous to do this for the membership as a whole. In the first place, many of our members are already covered by one or more obligatory Blue-Cross, Blue-Shield types of policies which are not infrequently fringe benefits of professional connections which are obligatory and incidental privileges of employment in some industrial, governmental, and educational establishments, and entail no direct financial outlay by the insured. Such members are already adequately covered by the present arrangements of the Society. Obviously it is much wiser for the individual member to obtain such coverage even at his own expense than it is to superimpose a program requiring a higher rate of premium upon the membership as a whole. In the second place the entire program of insurance coverage for medical care, as it presently exists, is age-related.

Because of such inescapable variations it is wise for the individual member to determine his own requirements and to take such steps as his individual needs dictate. Examination of the November 1968 edition of the Membership Insurance Programs booklet — available without charge from the Committee on Medical Defense and Insurance (The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605) — is the first important step in that direction. To those programs we have now added a Hospital Daily Indemnity Policy for those members who, after examination of their needs, feel that they require additional protection against higher medical costs. This policy, to be developed by E. & W. Blanksteen Agency, will be specially designed to accord with our present disability and major expense policies for those desiring supplemental coverage. Benefits will be in the form of a daily indemnity paid while hospital confined.

Life Insurance—Nationwide Life Insurance Company

Our life insurance program provides a five-year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance. The program provides up to $100,000 of coverage in units of $10,000 with a waiver of premium and double indemnity for accidental death included without extra premium charge.

In 1968, 20 of our members who participated in this program died. One of our deceased members held $50,000 of life insurance. Ten of the deceased policyholders obtained their insurance because of the qualification of the group in the initial enrollment and would not have been eligible for insurance under normal underwriting regulations. Through the very large volume of insurance and strong participation of our members in this program, we are able to have life insurance at a very low cost and yet provide this important coverage for such members. Since the inception of the life insurance program in 1959 there have been 158 death claims with a total of $1,599,000 paid out in benefits. At the present time, 1,748 of our members participate in this program, with $25,660,000 of insurance currently in force.

Six Point High-Limit Accident Insurance Plan

Our Six Point High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company provides up to $200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature, at less than the usual cost of the accidental death benefit alone. Special spouse coverage is available under this policy at very low cost. Of our members, 686 participate in this program.

Recommendation

That the E. & W. Blanksteen Agency be continued as the official broker for our Accident and Health High-Limit Accident, Life, Hospital Income, and Major Expense Programs.

Approved (page 414)

Professional Acts Liability Program

In the field of professional liability, our present insurance protection carried by Employers Insurance of Wausau is now fully activated and is serviced through the Joseph A. Britton Agency, which places insurance only for members of MSNJ. Employees, not members of MSNJ, of insured physicians are to be considered eligible for this protection subject to underwriting standards of the insurance company. An applicant who has been licensed to practice medicine in New Jersey conditionally by virtue of his declaration of intent to become a new citizen may apply for membership in MSNJ through a component society. This applicant shall be considered as any other applicant and be eligible for insurance protection pending action on his application for membership.

A member physician with practice of more than 50 per cent in another state generally is not considered eligible for insurance coverage under our program. This applies to those physicians in military service whose practice is predominantly outside New Jersey. Our Loss Control Program is administered by County Medical Review and Advisory Committees. They are established by the insurance company, our broker, and the attorney assigned by the company. This program was revised and approved in September 1968. Copies of the revised program were mailed to each component society. The program now in force includes all the features formerly operative with American Mutual. In addition, principles have now been designed to protect the circumspect practitioner from being penalized for liabilities incurred by his less fortunate colleagues. In other words, the practitioner who has repeated claims will find his rate rising in proportion to the frequency and severity of such claims. For this program to operate properly experience data are necessary, and during the past year the previous insurance carrier was asked to provide us with loss experience and other data. This was necessary to apply fair surcharges to all subject members under the new rules. The information also was important to proceed properly with investigation of a possible self-insurance program. Unfortunately, the company refused to give us any information.

The surcharge program has been approved by the New Jersey Department of Banking and Insurance. Surcharges of 50 per cent to 500 per cent of the applicable premium charge will be applied on renewal policies for those members with law suits of liability or claims to be settled in excess of defined limits. The

limits apply to number of cases and period of time, giving weight to the fact that surgical specialties recognize greater loss potential in the premium charge. A 50 per cent surcharge will be made when two qualified cases are reported in the applicable period, 150 per cent if three are reported, and 500 per cent if four or more are reported. The applicable period is ten years for classes of practice rated as 1 or 2, which cover practices with no surgery or minor surgery. The period is seven years for class 3, which includes proctology, ophthalmology, general practice with major surgery on non-referred cases, tonsillectomies and adenoidectomies, Caesarean sections, and assistance at major surgery on patients other than your own. The period is five years for classes 4 and 5, which include the surgical specialties and anesthesiology. A possible self-insurance program was thoroughly investigated. Several other medical societies also have investigated this possibility. A self-insurance program requires the ability to reinsure for catastrophic losses and there appears to be no acceptable market for such reinsurance in our country or Europe. If the unfavorable atmosphere of medical malpractice claims improves, which seems unlikely for the next few years, this avenue may be re-examined. To implement such a program, 100 per cent of the members of our Society would have to participate.

The insured physicians as of 24 January 1969 are as follows:

		Insurable	
County	*Members*	*Insured*	*Per Cent*
Atlantic	192	52	28
Bergen	897	618	69
Burlington	185	87	47
Camden	443	215	49
Cape May	46	16	35
Cumberland	112	56	50
Essex	1,679	1,070	64
Gloucester	84	36	43
Hudson	578	344	60
Hunterdon	56	49	88
Mercer	504	159	32
Middlesex	406	291	71
Monmouth	407	254	62
Morris	380	250	66
Ocean	133	84	63
Passaic	642	399	62
Salem	47	8	17
Somerset	138	102	74
Sussex	47	42	90
Union	691	450	65
Warren	47	18	38
Totals	7,714	4,600	59.7

Due to the change in insurance carriers in the past year, our Committee cooperated with the Britton Agency to send necessary information and forms to all our members. Unfortunately some delayed application for insurance beyond the expiration date of 1 November. In view of what is happening in the field of professional liability, participation by our members is dangerously low.

Last year's report described the previous company's requested rate increase of over 52 per cent. Our new company increased rates 10 per cent for classes 1 and 3 and 20 per cent for other classes. The trend in other states is worse with several states receiving over 100 per cent increases and most having very substantial increases. New York state had a substantial increase last year and there is information indicating another increase for 1969 of 40 per cent or more. It is believed that the agency filing for rate increases in New Jersey plans increases in 1969 from 25 per cent to 45 per cent. All indications lead the Committee to believe that a flood of increases will occur across the country this year.

Our agreement with Employer's Insurance of Wausau provides for rate levels to be examined each year for possible revision to correspond with loss experience, the upward pace of inflation, and other factors. The company, in considering national trends, as well as its own experience in New York and other states, feels an increase for 1969 is necessary. After discussion between the company and Mr. Britton, our broker, it was agreed that a 10 per cent increase in all classes would be satisfactory for 1969. In view of the foregoing information, our Committee feels this agreed increase is lower than should be expected and our members should accept it with appreciation rather than complaint. The cost is still much lower than it would have been last year with the previous company.

Through their filing agent over a year ago, other companies placed the specialties of anesthesiology, obstetrics-gynecology, neurosurgery, plastic surgery, and otolaryngology in the higher-priced class 5, in which we have only orthopedics. As a result of the company's

experience and review of past New Jersey experience, it will move the specialties of anesthesiology, obstetrics-gynecology, and neurosurgery into class 5. Within the past year, the national ratemaking organization for professional liability filed a new table of excess limits factors in substantially all states. The New Jersey Department of Banking and Insurance approved the new table. It was pointed out that the table had not been revised for many years, and loss experience excess of basic limits has been reportedly very bad in recent years. The Committee has approved this change, which will increase the cost for insurance for higher limits coverage.

Professional Premises Liability

The Membership Insurance Programs booklet mentioned several times before contains, on page 3, a summary of the coverage available for liability for torts arising in connection with professional premises.

Personal Catastrophe Coverage

Our Committee became aware of other insurance companies' offering policies for professional liability and catastrophe or umbrella coverage at lower costs. After investigation, it was found that the offering was on a selective basis or involved possible restricted or limited coverages. The Committee strongly recommends only the approved policies of our program. Physicians insuring outside of the program do not have the added protection of our Committee and program in participation and decision-making under the agreement with our approved company.

Automobile Insurance

The Essex County Medical Society has been quite insistent that this Committee obtain coverage on a state-wide basis for its members who have been unable to get individual automobile coverage. The issue here is very simple — a request for the Society as a whole to carry bad risks in a bad risk area in a state where automobile coverage is unfavorably regarded by the carriers. Such a plan was previously attempted in Essex County and proved to be a failure because of inadequate participation. The problem has been re-explored recently on several occasions. One agency (Donnelly) agreed to pursue this matter further providing a high percentage of participation could be generated at a state-wide level. Since many physicians purchase their automobile insurance as part of a general package-deal there seems to be little enthusiasm for such a program outside Essex County. Moreover, many physicians in the northeast area rent their professional vehicles because of the improved tax status of such arrangements and rented vehicles are covered by blanket insurance programs issued to the leasers. In view of doubtful participation by even the northeastern membership, Essex County has been requested to poll its own membership with respect to prospective participation. It has reported its inability to do this until the exact conditions of offer are made known. Since these two variables are mutually interdependent, there appears to be no practical way to solve this problem until at least Essex County membership as a whole is willing to commit itself to a group plan in which the rate for good experience members would obviously be substantially raised in order to cover the risk incurred by the inclusion of other members who now occupy the position of uninsurable risks.

Problems of the Future

Before closing this report, which marks the retirement of both the chairman and vice-chairman of the Committee, a glance toward the future is in order. Two independent forces will shape the professional liability situation of the future.

The first of these, which affects all aspects of our insurance coverage, is the long-range *economic outlook of the insurance industry.* Regrettably this is clearly unfavorable because of inevitable inflation, the introduction of social considerations into judicial philosophy, and the increased tendency of government to usurp fiduciary activities. No comment is required with regard to inflation, but the membership must understand that the issue of liability is becoming of less significance to the bench than making certain that

a person with a claim does not become still one more public charge. Furthermore, there are clear indications that a certain sector of government economists are looking toward the day when all can place their entire insurance programs with the Social Security Administration by filing applications in their local post office.

There is a second force operating in the field of professional liability. This is the *changing face of medicine,* and involves alterations in medical education, technological changes, and revisions of the ethical atmosphere of professional practice. Because of alterations in the educational programs of medical schools, the graduate of the future may very well find himself with a limited license in an area where more or less of the practice of medicine has been transferred to certified paramedical personnel. The introduction of the degree of Doctor of Medical Sciences probably marks the entrance of the medical educational establishment into a system of divided allegiance with the doctor of medicine at the top of the medical pyramid and the doctor of medical sciences at the apex of the paramedical pyramid. It would appear that entry of paramedical forces into diagnostic fields is well enough advanced to require only formal recognition in order to replace personnel holding the doctorate in medicine. This is going to complicate, enormously, not only the issue of liability but also the problem of obtaining information, and the processing of claims and trying of suits.

Of all the problems being introduced by technological change, the most difficult at present is the issue of iatrogenic disorders. The modification of the natural history of disease by pharmacological therapeusis, especially where more than one drug is being used (and more than one physician is treating the patient), is already a very serious problem.

Reconsideration of ethical issues, with a view to relaxing traditional restrictions on medical activities, is also introducing some bewildering difficulties. The enormously increased liability exposure of obstetricians, functioning in areas where laws governing contraception and abortion have been altered, may very well result in a flight from such a specialty in such areas. For example: suits are being brought for huge amounts in cases where obstetricians did not abort a mother who subsequently gave birth to a mentally defective child. Again, can the general practitioner whose patient sues in connection with a contraceptive case disprove alleged bias against race or creed or genocidal intent? If we add, to contraception and abortion, the potential difficulties arising out of artificial insemination and sterilization, the obstetrician's exposure begins to assume major medico-legal proportions.

Extremely thorny are problems of the determination of death and elective death, issues of human experimentation and organ transplants, the relation of the physician to war, the military establishment, and to law enforcement agencies. What about the physician and socio-economic problems? What is the extent of liability of an insuror if a physician incurs a suit because he is involved in a doctor's strike, or, again, what if he expresses a disinclination to participate in a strongly supported municipal or other governmental program? Professional secrecy is currently subject to attack, as is the physician's relation to the drug industry. Psychiatry seems to be coming apart at its ego seams. One Professor of Psychiatry (Thomas Szasz) advocates abandonment of a medical frame of reference, and the adoption of a sociologic point of view. He would, for example, jettison the principle of impartiality in psychiatric practice and espouse the development of a frank split of psychiatric practice into claimants' psychiatrists and plaintiffs' psychiatrists. How would insurance programs encompass coverage for such activities?

What are we to do about the increasing number of physicians who are being sued not for professional liability but for assault. Such claims may arise when, in the course of examining a compensaion-case-claimant, a physician moves a limb and the patient subsequently deposes that such a contact has produced irreparable injury.

The traditional relation of the physician to the hospital and medical school is being rapidly altered. The hospital is in the peculiar position of being able to develop huge capital gains by exploitation of its professional staff. In situations where teaching institutions control hospitals, the possibilities of financial accumulations are enormous — some at the expense of the physician. It is not to be imagined that such a mechanism will permit the hospital-based physician to manage professional liability suits against himself since the hospital would obviously also be joined. How is such a conflict-of-interest situation to be handled?

In what appears to be a wildly proliferative and disorderly future, it will become increasingly difficult to contain the professional liability needs of our Society unless some ground rules are laid down for what is going to be covered and what is not, and unless a good deal of effort is expended to keep abreast of the general situation, and to find the best solution to the problems of the moment, in a rapidly changing situation. In all this it must be remembered that the Committee on Medical Defense and Insurance consists of only a few members and that they are busy practitioners. Your cooperation, and your appreciation of the difficulties involved, will surely be most welcome.

Recommendations

(1) That Employers Insurance of Wausau be continued as the official professional liability insurance carrier for The Medical Society of New Jersey for 1969-70.

(2) That the Joseph A. Britton Agency be redesignated as The Medical Society of New Jersey's official broker for its professional liability coverage.

Approved with commendation to Fred A. Mettler, M.D., Chairman of the Committee on Medical Defense and Insurance, and to Ernest C. Hillman, Jr., M.D., Vice Chairman, for the work of their Committee and for the completeness of their final report (page 414)



House of Delegates — First Session

Medical Education

Louis F. Albright, M.D., Chairman, Spring Lake
(Reference Committee "D")

The Academy of Medicine of New Jersey has labored in the field of continuing education since 1911 and has been the official educational arm of The Medical Society of New Jersey for the past three years.

Presently programs are divided into three categories — major symposia, roving symposia, and section meetings. The major symposia are publicized to all physicians in the State and are sufficiently broad in scope to attract attendance from all areas of interest and practice. The roving symposia are made up of small panels and present a given topic in several geographic areas of the State so that the physician need not travel far from his home base to take advantage of the meetings. Section meetings are publicized to that specialty society with which they are concerned, although attendance is open to any physician interested in the topic being presented.

At its recent clinical convention in Miami Beach, the AMA House of Delegates urged state medical societies to maintain a continuing and active liaison through functioning chapters of SAMA. Subsequently the Board of Trustees requested that the committee establish active liaison and possible rapport with local chapters of SAMA. In an effort to carry out this charge, and with the approval of the Board of Trustees, two representatives of each of the SAMA chapters in New Jersey have been invited to attend our 203rd Annual Meeting at Society expense.

Thus we may achieve a closer working alliance with the medical student in New Jersey.

Approved with the following recommendation: That the Chairman of the Committee on Medical Education extend an invitation, through the Deans of the two New Jersey medical colleges, to medical students to attend the Annual Meeting of The Medical Society of New Jersey in 1970, and to visit the exhibits and scientific sessions. It is suggested that there be a special student registration with a distinctive badge. (page 415)



Dr. Stewart Alexander accepts from President Kustrup MSNJ's check for its contribution to The Academy of Medicine of New Jersey.

Medical Student Loan Fund

Frank J. Hughes, M.D., Chairman, Camden

(Reference Committee "B")

In its twelve years of operation the Medical Student Loan Fund has granted loans totaling $220,244.35, including $444.35 as insurance payments, making the net loans granted $219,800.00.

To date the Fund has issued 224 loans to 135 New Jersey medical students. Thirty loans have been repaid in full. Fifteen borrowers are presently making quarterly repayments on an annual basis, and three borrowers are presently making interest payments only.

For the third consecutive year, a time-cost study of Fund operations was conducted. It showed an average administrative cost to MSNJ of approximately 8 per cent for each $1,500.00 granted.

The outside auditor, in conducting his routine audit of the Medical Student Loan Fund as of 31 May 1968, noted in the Fund's 1968 Annual Report to the House of Delegates reference to this cost summary. It was his opinion, that the reimbursement of such costs to the general fund is not desirable for the following reasons:

(1) A general fund budget appropriation is made each year to the Medical Student Loan Fund as a gift. The reimbursement of estimated administrative costs would only serve to reduce the amount of this gift and thereby reduce the funds available for the purposes of the Fund.

(2) It is very difficult to determine accurate administrative costs for the granting of a loan, and such costs may vary on student loans because of man factors.

(3) The charging of administrative costs would increase the bookkeeping function. It is the auditor's objective to keep the Society's record-keeping as simple as is compatible with completeness and accuracy.

(4) The Fund is still growing. At a future time, if the annual budget appropriation is terminated and the cost of administrating the Fund increases, it might then be decided to reimburse the general fund for administrative costs.

Therefore, the committee has unanimously concluded that the study should be discontinued until such time as it is deemed feasible to consider charging administrative costs directly to the Medical Student Loan Fund.

Present Location of Recipients of Loans

The 102 graduates are located as follows:

7 Interns — 5 in New Jersey and 2 out-of-state

42 Residents — 19 in New Jersey and 23 out-of state

39 Armed Services—31 Army of the United States and 8 United States Navy

13 Private Practice — 7 New Jersey, 2 Pennsylvania, 2 California, 1 Connecticut, and 1 Massachusetts

1 Unknown (currently uncollectable)

12 Students presently in medical school — 3 seniors, 7 juniors, and 2 sophomores

114 Current student loans outstanding

21 Medical students paid in full

135 Total New Jersey Medical Students (as listed earlier)

Contributions

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; Hudson County Medical Society; County Woman's Auxiliaries: Atlantic, Bergen, Burlington, Cape May, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Passaic, Somerset, and Warren, Mr. and Mrs. Fred Adams, Dr. and Mrs. Sotiris Athans, Broad Street United Methodist Church — Primary Department, Edith Stokes Bloomer, Mrs. J. R. Butler, Dr. and Mrs. Eugene Childers, Mrs. Kathina Ciapa, June Cooper, Dr. and Mrs. Robert Cornwell, Edison High School (Faculty), Edison High School (Foreign Language Department), Edison High School (Mrs. Kolbay's Students), Dr. and Mrs. E. Ellenson, Peggy and Josie Ellenson, Mr. and Mrs. William Finegan, Dr. and Mrs. Philip Fiscella, Joseph M. Fitzgerald, M.D., Mr. and Mrs. Edward Gessner, Dr. and

Mrs. Floyd Gindhart, Mrs. Edwina Gulyas, George and Roberta Hart, Dr. and Mrs. John Helff, Mrs. Helen C. Hendrinson, Dr. and Mrs. Harold Hughes, Dr. and Mrs. Edward Jasionowski, Florence M. Jones, Mrs. Edward C. Kehoe, Dr. and Mrs. Jack King, Dr. and Mrs. Philip J. Kunderman, Dr. and Mrs. John F. Kustrup, Mr. and Mrs. Peter Lamprakos, Dr. and Mrs. Samuel J. Lloyd and Family, Bernard and Ruth Meyerowitz, Dr. and Mrs. Saverio Monaco, Miss Frances A. Nesladek, Mr. and Mrs. Ernest Parker, Dr. and Mrs. Peters, Dr. and Mrs. Paul H. Pettit, Mrs. Paul E. Rauschenbach, Mrs. James Rogers, Rutgers Preparatory School — Junior Class, Rutgers Preparatory School — School Council. Dr. and Mrs. Nicholas Scielzo, Dr. and Mrs. John Scillieri, Mrs. Naoma H. Seymour, Dr. and Mrs. Ned Shaw, Ruth S. Silpath, Dr. and Mrs. Sidney Smith, Dr. and Mrs. Paul R. Sparks, Mr. and Mrs. Harry G. Stagg, Dr. and Mrs. N. Suelzo, Mrs. C. S. Tarta, Mildred and Lucius Tarchiani, Mr. John E. Tilkey, Dr. and Mrs. John Torppey, Mr. and Mrs. Raymond Walvin, Mr. and Mrs. Sigmund Weissman, Mrs. J. H. Woolman, Sr., Olive and David Zuckerman.

In Memory Of

E. J. Allen, M.D., Mrs. Mary Kohut Ballas, Joseph Berg, William E. Bray, M.D., Paul C. Cameron, M.D., Mrs. Helen Captanian, Mr. Frank Centrone, Mr. Harry Cocker, Maurice Cohen, M.D., Antoinette Curcio, Phillip R. D'Ambola, M.D., Mrs. Morando De Fronzo, Harry E. Di Giacomo, M.D., Richard C. Drewes, M.D., F. M. Engelhart, Ralph Fan, Mr. Ralph Faulkingham, Mrs. L. A. M. Feher, Mrs. Janet Fisher, Mrs. Mary Feller, Rober E. Geyer, William Gleeson, M.D., Theodore Graham, M.D., Mrs. Bernard Hirshfield, Mrs. Hoffman, Mrs. Otto Holters, Mrs. Ianacone, Archie Johnson, M.D., Mr. Jack Krauthamer, T. Lloyd Kolbay, M.D., Nancy Lloyd, Mrs. H. C. Meyer, B. Michael Miley, Isabel Nayfield, Mrs. Neorino, George Obrash, Harold Parmelee, Jr., Samuel J. Pecora, M.D., Ernest F. Purcell, M.D., Mrs. Ruth E. Reed, Frank Riggo, Victor Ritschard, Ann and Mary Rosato, Mrs. Leo Schultz, Edward Sciorsci, M.D., Reuben L. Sharp, M.D., James S. Shipman, M.D., Mrs. Anne Starrs, Mrs. Isabelle Summers, Miss Karen Marie Torppey, Edward Tyson, M.D., Henry L. Van Mater, M.D.

In Honor Of

Dr. and Mrs. S. Athans; Miss Phyllis De Palma; Mrs. John F. Kustrup; Mrs. Edward MacDonald; Passaic County Woman's Auxiliary Executive Board.

DISTRIBUTION OF LOANS

County of Residence	*Medical School*	*Students*	*Loans Granted 1957-1968*	*1968-1969 March 31, 1969*
Atlantic	Hahnemann	3	$ 3,000.00	
	N. J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Hahnemann	3	5,000.00	
	N. J. Medical	7	11,000.00	
	N. Y. Medical	1	1,000.00	
	St. Louis	1	1,500.00	
Burlington	Duke	1	4,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	2	2,000.00	$1,500.00
Camden	Jefferson	2	2,000.00	
	Michigan	1	2,000.00	
	N. J. Medical	2	2,700.00	
	Temple	5	3,500.00	$2,500.00
	Hahnemann	2	2,000.00	
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	4,000.00	
	Bern	1	2,000.00	
	Duke	1	2,000.00	
	Hahnemann	3	5,000.00	1,500.00
	Howard	1	300.00	
	Jefferson	1		1,500.00
	N. J. Medical	9	16,500.00	
	N. Y. Medical	2	2,000.00	
	St. Louis	1	500.00	
	Temple	1	1,000.00	
	Georgetown	1	1,000.00	
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00	
	U. of Virginia	1	1,000.00	
Hudson	Georgetown	1	1,000.00	
	Harvard	1	1,000.00	
	Howard	1	400.00	
	N. J. Medical	18	26,150.00	
	N. Y. Medical	1	1,000.00	
	Pittsburgh	1	3,000.00	
	St. Louis	1	2,000.00	

DISTRIBUTION OF LOANS—*Continued*

County of Residence	*Medical School*	*Students*	*Loans Granted 1957-1968*	*1968-1969 March 31, 1969*
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N. J. Medical	4	8,000.00	1,500.00
	U. of Penna.	1	1,000.00	
	St. Louis	1	700.00	
	U. of Louisville	1		1,500.00
Middlesex	Georgetown	1	1,500.00	
	Hahnemann	1	4,000.00	
Monmouth	Columbia	1	2,000.00	
	Georgetown	1	1,000.00	
	Jefferson	1	3,000.00	
	Marquette	1	2,000.00	
	N. J. Medical	3	7,000.00	$1,500.00
	N. Y. Medical	1	4,000.00	
	Temple	1	2,000.00	
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	N. J. Medical	1	3,000.00	
Passaic	Jefferson	1	3,000.00	
	N. Y. Medical	1	1,000.00	
Somerset	Georgetown	1	1,000.00	
	N. Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	1		$1,500.00
	N. J. Medical	11	17,800.00	
15 Counties	29 Medical Schools	135	$206,800.00	$13,000.00
Total loans granted 31 March 1969				$219,800.00

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee — approving a budget appropriation of five thousand dollars in lieu of a special per capita assessment for 1969-70 in support of the Medical Student Loan Fund.

(b) That the MSNJ membership be urged to continue to send contributions to the Fund.

(c) That the Woman's Auxiliary to The Medical Society of New Jersey again be requested to keep the Fund one of its primary objectives during 1969-70.

(d) That the time-cost study of Fund operations approved by the Board of Trustees be discontinued until it is deemed feasible to consider charging administrative costs directly to the Medical Student Loan Fund.

Approved with the recommendation that the loans be continued for those eligible students who require them **(page 413)**

A Primer About Braces

Now available is a *Primer About Braces,* a 32-page, profusely illustrated manual dealing with construction and use of braces and splints with hints on the proper care of braces. Included is material on surgical and orthopedic corsets. Though intended principally for nurses, it will be a useful brochure for all medical personnel who come into contact with patients who wear braces. You can get a copy for 85¢ from the American Rehabilitation Foundation, 1802 Chicago Avenue, Minneapolis, Minnesota 55404.

Publication

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")

Some question has been raised about *The Journal's* deficit. Actually, it is not necessary to the interest of the Society to develop a profit. Apart from that, the deficit is due in large part to expenses we incur in publishing certain items mandated to us. *The Journal* is the house organ of The Medical Society of New Jersey, and it properly includes items referred by the Board of Trustees and the councils and committees. We are not concerned with the amount of material submitted, but we suggest that there might be some consideration of the way these activities are charged in the Society's books.

The Journal must operate without profit. Yet postal regulations and the interests of our advertisers require a certain ratio of advertising to text, thus limiting our control over the number of pages in a given issue.

The office of the Secretary of the Society is responsible for recording the Annual Reports and Transactions of the House of Delegates; but the expense of publication of this permanent record is charged against *The Journal*. In 1967, the Transaction Issue (July) ran 160 pages and cost $7,642. In 1968, the charge was $7,681 for 150 pages. July is always a special issue with a certain prestige, and advertising income is up some $500 over that of another month. The cost of an average issue — excluding Transaction Issues — is at present $3,921. Per page, the average cost has been about $35. In 1968, we published 32 pages of the 1968 Annual Meeting program, 7 pages at the request of the 1969 Annual Meeting Scientific Exhibit Committee, some 20 pages suggested by the Council on Mental Health, and lesser amounts from the Committee on Emergency Medical Care, the Committee on Air Pollution, and so on — all of which have been welcome, and all of which have been charged against *The Journal*. Our monthly report from the State Department of Health runs one to two pages. It has been well received and is a worthy expenditure.

At the request of the Academy of Medicine we run articles publicizing the facilities of the Academy. In addition we publish some 10 to 12 pages each year listing new library acquisitions.

At the direction of the Board of Trustees, *The Journal* initiated a "Meetings of Medical Interest" section. This has run as high as five pages in one issue, for a total of 33 pages *this* year at a cost of nearly $1,200. Perhaps we should revalue the worth of this section.

Advertising rates were increased as of 1 July 1968, and are now effective on all but a few contracts. This will help to offset the increased printing costs, which apparently will occur annually in accordance with the cost-of-living and labor increases. At this writing our printer has asked for an 8 per cent rise in his prices, and the proposal is under consideration. Our advertising pages dropped from 788 to 714 during the calendar year 1968. This drop is consistent with the reduction in advertising dollars in the drug field for professional publications. The advertising future is somewhat uncertain again this year, because no one can predict what the Food and Drug Administration will do with respect to additional restrictions on advertising copy submitted by pharmaceutical manufacturers. The lag in new drug approvals further places advertising plans in a state of uncertainty.

Here is the box score for the last four years:

	1965	1966	1967	1968
Total of Text Material	592	578	704	708
Advertising	485	660	788	714
Grand Total of Pages	1077	1238	1492	1422
Ratio: Advertising/Text	45%	53%	53%	50%

Mr. Cookson continues to prove himself a dynamic and effective advertising manager who never forgets the ethical side of his work. Only advertising acceptable to the committee is approved.

At the request of the Editor and your Chair-

man, Mrs. Treptow was promoted to Assistant Editor last year. She performs efficiently in that capacity, as well as secretary to the Editor, reader of all proofs, hostess to phone calls and visits from authors, members, and readers, general factotum in the editorial department, and Girl Friday in *The Journal* office.

Dr. Davidson is one of the senior state journal editors in the USA. He is a frequent speaker at editorial conferences throughout the country, and his *Guide to Medical Writing* (Ronald Press, New York City) is a standard text for authors and editors. He wrote the item on the history of organized medicine in New Jersey for the February 1969 issue of *Massachusetts Physician*, which started a series of articles on the histories of state medical societies.

We have a small office for our *Journal* — Mrs. Treptow is the only full-time employee there — and we do a prodigious job. We, of the Publication Committee, are proud of our product and hope you are, too.

Approved (page 413)

Revision of Constitution and Bylaws

John J. Thompson, M.D., Chairman, Caldwell

(Reference Committee on Constitution and Bylaws)

The 1968 House of Delegates referred three resolutions to the Committee for study and report to the 1969 House. Our disposition of these matters appears below.

1. *Resolution #26 — Constitutional Amendment to Effect More Proportionate Representation on the Board of Trustees*

This proposal calls for one trustee from each judicial district and an additional trustee for each additional five hundred members or major fraction thereof.

The Committee agrees with the opinion of the Reference Committee on Revision of Constitution and Bylaws that Resolution #26 was an attempt to revise the Constitution by means other than that which is proper according to the Constitution.

After studying this Resolution closely, the Committee offers the following:

Recommendation

That in view of the recent amendment to the Constitution effecting new proportionate representation on the Board of Trustees, a satisfactory interval of time be allotted — no less than three years — to ascertain the effectiveness and adequacy of the new Constitutional provision.

Tabled (page 427)

2. *Resolution #27 — Establishment of an Ad Hoc Committee to Redistrict the State to Provide Proportionate Representation on the Board of Trustees*

The recently adopted (1968) Constitutional amendment affecting Board membership has not been in existence long enough to support proper evaluation, and, in view of our position on Resolution #26, the Committee offers the following:

Recommendation

That no action should be taken in this area at the present time.

Approved (page 427)

3. *Resolution #35 — Osteopathy*

We concur in the decision of the 1968 House of Delegates that approval of this Resolution

would have been contrary to the Charter and Bylaws of MSNJ as they now exist.

This resolution and its subject matter should not be re-considered until a policy decision has been made by the House of Delegates concerning the admission of osteopaths to MSNJ membership.

The Committee was informed that at least one resolution calling for such a decision will be presented to the 1969 House. It was therefore the decision of the Committee to defer further consideration of this matter pending action by the 1969 House of Delegates in the area of policy.

Report of the AMA Delegates

The Committee reviewed two items in the Report of the AMA Delegates which were referred to them by the Board of Trustees at their 22 December 1968 meeting. Classification of membership and the admission of osteopaths are matters calling for a major policy determination. The Committee noted that this issue will be brought before the 1969 House of Delegates through the introduction of a resolution.

Revision of Bylaws Pertaining to Citizenship Requirements

In April of 1968 the Medical Practice Act was amended to provide that a foreign physician who files written declaration of his intent to become a United States citizen shall become eligible for admission to the examination for licensure. Upon successful completion of the examination, he will be granted a plenary license effective for up to no more than eight years. At that time he shall provide evidence of attained citizenship and his license shall become permanent. If at that time he has failed to acquire citizenship, his license is automatically revoked.

Since this amendment to the Medical Practice Act, many applications for membership to MSNJ have been received from physicians licensed under it in New Jersey. Because The Medical Society of New Jersey was a prime mover of this legislative change, the Board recognized that MSNJ Bylaws would have to be amended to require citizenship or declaration of intent therefor of prospective members if licensed non-citizen physicians are to be eligible for MSNJ membership. Accordingly, the Board referred the matter to the Committee on Revision of Constitution and Bylaws for preparation of a proper amendment for submission to the House of Delegates.

Exhibit #1

After extensive discussion, the Committee unanimously agreed upon the following proposed amendment to Chapter IX, Section 2, paragraph (b), subsection (1) of the Bylaws. (Exhibit)

(Prepared and Submitted by the Committee on Revision of Constitution & Bylaws)

Bylaws

Chapter XI — Component Societies

Section 2 — Qualifications of Members

Current	*Proposed*
(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.	Same
(b) To be eligible for membership, the applicant must:	Same
(1) be a citizen of the United States;	(1) be a citizen of the United States *or have filed with the State Board of Medical Examiners a formal declaration of intent to become a citizen;*
(2) hold a degree in medicine acceptable to this Society obtained from a medical school approved by this Society at the time of his graduation;	Same
(3) be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners;	Same

Approved (page 427)

Woman's Auxiliary Advisory

George O. Rowohlt, M.D., Chairman, Dumont

(Reference Committee "H")

The official programs and projects for 1968-69 were submitted to and approved by the Board of Trustees.

The Auxiliary's program is an on-going one; the basic aims and structure of the Woman's Auxiliary continue from year to year.

This year the slogan of the Auxiliary to The Medical Society of New Jersey was "Serving the Public Through Our Service to the Medical Profession." County auxiliaries worked closely with their medical societies, assisting in community health days, health career programs, and a three-day health fair.

The State publication, "The Shingle" has information for every member in the state; *The Journal* of The Medical Society of New Jersey carried an article on membership; and *M.D.'s Wife,* a National publication, January issue, published an article on the special political service doctors' wives of a New Jersey county are giving to their community.

Following the Eastern Regional Conference, a State fall conference was held with round-table discussions held on AMA-ERF, Community Service, Disaster Preparedness, Legislation, Medical Student Loan Fund, Mental Health, Membership, Programs, Health Careers, and Safety. The film "Horizons Unlimited" was shown.

Two copies of the film "Horizons Unlimited" were purchased and presented to the Film Library of the State Museum, Trenton.

The Board of Trustees of The Medical Society of New Jersey has granted permission to the President of the Woman's Auxiliary to present a report at the opening session of the 1969 House of Delegates concerning the activities of the Auxiliary during the year. Approval was also given to the Auxiliary to participate in the National campaign to end TV and Movie Violence which is part of the program, "Accent on Youth."

The Auxiliary is sponsoring two WA/SAMA groups (Woman's Auxiliary to the Student American Medical Association) in Camden and Essex County. Financial help is given as well as fostering a spirit of friendship and cooperation.

Many county auxiliaries have assisted their medical societies in the yearly eye-health screening program. Members have worked in the youth field and on drives such as cancer, heart, polio, TB, and Red Cross. Programs were sponsored on problems of the aging, venereal disease, and drug addiction.

Medical Student Loan Fund, AMA-ERF, and health career scholarships have firm financial support from the counties, and benefit from the sale of note paper with sketches of scenes of New Jersey done by Auxiliary members.

Information on current medical legislation was given to the counties, and the members of the Executive Board visited the State Legislature following its March meeting. The president and legislative chairman were recognized by the legislative body.

A dues increase of two dollars per member will be sent to the National Auxiliary beginning in 1970. Annual dues for National will then be four dollars. The State Auxiliary has not requested an increase in State dues; they will remain at two dollars per member.

It is with pleasure that the Committee again expresses appreciation to the officers and members of the Auxiliary for continued support to The Medical Society of New Jersey and its programs, and for their cooperative efforts to protect and promote the art of medicine and the betterment of public health in New Jersey and for "Serving the Public Through Service to the Medical Profession."

Approved (page 426)

Administrative Councils

Legislation

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1968 legislative year and a record of the bills of medical interest in the 1969 Legislature thus far, together with a brief description of, and the Society's official position on, each piece of legislation. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies and in items published in the *Membership News Letter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The 192nd (1968) session of the New Jersey Legislature was adjourned *sine die* at noon on 14 January 1969. That session was one of the busiest in State history. 969 bills were introduced in the Senate and 1,000 bills in the Assembly. In addition the Senate considered 91 resolutions of various types and the Assembly 85. The unprecedented total of all legislative measures in the session reached 2,145.

The Council on Legislation took a position on 116 measures as bearing directly upon the Society's interest and concern. Of this total: (a) 3 bills actively supported became law; (b) 1 bill actively supported received a pocket veto; (c) 2 bills actively opposed received pocket vetoes: (d) 13 bills approved were signed into law; (e) 1 bill disapproved by MSNJ became law; and (f) 4 bills on which MSNJ had a position of no action were enacted.

Actively Supported Bills Signed Into Law

S-274—Grants a person the privilege in a civil action or in a prosecution for a disorderly person or juvenile deliquency to refuse to disclose confidential communications between physician and patient . . . Chapter 185

S-546—Provides that the consent of minors to treatment for venereal disease shall be valid and binding . . . Chapter 230

A-511—Provides that a statement of physical fitness of a minor seeking employment may be signed by any physician licensed to practice medicine and surgery . . . Chapter 314

Actively Supported Bill Given Pocket Veto

A-549—To prohibit solicitation of patients by persons licensed or registered to diagnose or treat human illness or deformities and to prohibit such solicitation or advertising by any agency or association on behalf of such persons.

This measure passed in both houses but on 10 March the Governor filed it in the State Library without his approval, alleging technical errors in the bill as drawn and declaring "there is a question whether the State should interfere in professional disputes which have no bearing on the health and safety of its citizens."

Actively Opposed Bills Given Pocket Vetoes

S-363—To provide that licensed chiropractors shall have the same privileges and benefits as licensed physicians and surgeons under the act governing medical service corporations . . . Pocket Veto on 7 March 1969

S-365—To provide that the services of a chiropractor shall be considered medical or surgical services under the Workmen's Compensation Act, any health and accident, disability or other insurance policy, or under any labor management trustee, union welfare, employee benefit, or any private insurance or welfare plans . . . Pocket Veto on 7 March 1969

Approved Bills Signed Into Law

S-119—Provides for the education of students for general practice in the professions of medicine and dentistry . . . Chapter 67

S-338—Provides that special arrangements for the proper disposition of the remains of a human body made available to science shall be the sole responsibility of the person entrusted to control such disposition and not of the receiving agency . . . Chapter 25

S-532—Increases pre-professional education requirements for podiatrists and permits the Medical

Board to recognize the examination given by the National Board of Podiatry . . . Chapter 216

S-607—Provides for the inspection of public and private facilities for the care, treatment, and discipline of children . . . Chapter 85

S-718—Provides, under contract with the Rutgers Center of Alcoholic Studies, for a study and pilot facility involving problems of the chronic drunkenness offender . . . Chapter 267

S-833—Appropriates $200,000 for establishing State Medical Examination laboratory facilities . . . Chapter 199

S-850—Establishes a medical assistance program for the needy (Medicaid) . . . Chapter 413

S-921—Appropriates $295,000 for the conduct of special educational services for children suffering serious sensory disorders attributable to the 1962-64 Rubella epidemic . . . Chapter 399

A-56 —Permits a non-citizen to qualify for licensure on the basis of a filed declaration of intent to become a citizen instead of requiring full citizenship as heretofore . . . Chapter 16

A-277—Provides immunity for civil damage suits to volunteer first aid or rescue squad workers who are not members of a volunteer fire company . . . Chapter 44

A-307—Permits the Board of Control to assess and collect penalties for violations involving care of patients in convalescent homes, private nursing homes, and private hospitals . . . Chapter 355

A-349—Provides for licensing and regulation of administrators of convalescent and nursing homes . . . Chapter 356

A-660—Establishes an x-ray technicians board and provides for regulation and certification of x-ray technicians . . . Chapter 291

Disapproved Legislation Signed Into Law

S-354—Provides immunity under the Good Samaritan Act to any person who in good faith renders emergency care at the scene of the accident . . . Chapter 254

MSNJ disapproved this bill because "it would expose victims of accidents to serious danger in consequence of well-meant but incompetent ministrations that could do more harm than good."

No Action Legislation Signed Into Law

S-450—Provides for the establishment of dental health plans subject to approval of the Commissioner of Banking and Insurance . . . Chapter 305

S-508—Permits the State professional boards and commissions to issue licenses to non-citizens who have filed declarations of intent . . . Chapter 144

MSNJ approved and was supporting A-56 (see above) which was signed into law (11 April) before S-508 began to move.

S-723—Provides for additional funds to be paid into the police and firemen's pension fund; defines a "child" to include a person of any age who is incapacitated because of mental retardation . . . Chapter 154

A-87 —Increases the major medical insurance coverage of public and school employees . . . Chapter 135

Status of Other Bills of Significant Interest

S-334—To provide that blood, blood plasma or tissue or organs shall not be considered commodities subject to sale or barter but shall be considered as medical services . . . Actively Supported by MSNJ, it passed in the Senate, but was lost in the Assembly and was recommitted.

S-526—This bill was introduced in both Houses, to
A-524—provide for the confidentiality of information and data secured by, and in possession of, hospital or extended care facility utilization review committees . . . MSNJ Actively Supported both measures on introduction. S-526 did not move. A-524 was amended in Assembly committee and passed the Assembly. It advanced to second reading in the Senate and thereafter remained in committee.

S-538—To provide for two public representatives on all professional boards . . . Disapproved by MSNJ, the bill did not come out of the Senate committee to which it was referred.

S-589—Two versions of a measure to authorize certain
A-925—persons to assist physicians or surgeons in providing limited ancillary technical procedures . . . Both bills were Actively Supported by MSNJ. S-589 did not move. A-925 had second reading in the Assembly but was recommitted.

S-722—To create a Physical Therapy Examining Board to register physical therapists; to prescribe its membership and functions; to define "physical therapy" . . . The original version of this bill was actively opposed by MSNJ. Following conference, S-722 was amended in the Assembly and MSNJ Approved it in its amended form. The amended measure passed in the Assembly and in the Senate, to which it was returned. It was given a pocket veto by the Governor who opposed removal of physical therapists from the supervision of the State Board of Medical Examiners and who declared against encouraging "the proliferation of professional and occupational licensing boards" and called for a "Cabinet-level," review of professional and occupational licensing.

S-825—To authorize the school medical inspector to accept the report of a physical examination of a pupil by his treating physician . . . Actively supported by MSNJ. The bill did not come out of the Senate committee to which it was referred.

S-904—To license and regulate medcal care facilities; transfer powers and duties to the Department

of Health from the Department of Institutions and Agencies; amend the act concerning hospital service corporations and hospital service plans, and reconstitute the board of trustees of the Hospital Service Plan to limit representatives of the health profession and of health care institutions to one-third . . . Disapproved by MSNJ. The bill did not come out of the Senate committee to which it was referred.

A-932—To designate the State Department of Health as the sole agency having the central, comprehensive responsibility for the development and administration of the State's policy with respect to hospital and related medical care services, and all public and private institutions — whether State, county, municipal, incorporated or not incorporated — except mental institutions and institutions for care of the mentally ill; to create a Health Care Administration Board . . . Disapproved by MSNJ. The bill did not come out of the Assembly committee to which it was referred.

Society-Supported Legislation Thus Far Re-Introduced

S-350—To authorize the school medical inspector to accept the report of a physical examination of a pupil by his treating physician . . . Re-introduced on 23 January 1969, by Senator Woodcock (Bergen). Referred to the Senate Committee on Education.

S-365—To provide for the confidentiality of information and data secured by and in possession of hospital or extended care utilization review committees . . . Re-introduced on 23 January 1969 by Senator Wallwork (Essex). Referred to the Senate Committee on Commerce, Industry, and Professions.

A-21 —To authorize certain persons to assist physicians or surgeons through providing limited ancillary technical assistance . . . Re-introduced on 14 January 1969 by Assembly members Ewing, Kean, Margetts, Timson, Azzolina, Mabie, Haelig, Garibaldi, Wilentz, Fay, Richardson, Brown, and Caputo. Referred to the Assembly Committee on the Revision and Amendment of Laws.

Revision of Operational Procedures of the Council

The 1968 House of Delegates directed that:

(a) "The Medical Society of New Jersey appoint its 'County Legislative Keymen' from a list provided by the President of each component society, so that there are adequate Legislative Keymen for the State Legislators;" and

(b) ". . . as indicated and necessary, the Council on Legislation, with the approval of the Board of Trustees, designate and use the services of a selected member or members of MSNJ or any other legislative assistant as official legislative liaison agents of the Society."

In fulfillment of (a), early in July 1968 letters were addressed to presidents of component societies soliciting nominations of county keymen. In consequence of their response, the list of county keymen was revised and expanded in preparation for the return of the Legislature on 15 September.

In furtherance of the second directive, (b), the Board of Trustees, on 17 July 1968, appointed John J. Bedrick, M.D. (Bayonne) and Louis K. Collins, M.D. (Glassboro) to serve as the Society's official legislative educational representatives, as the Society's legislative interests required. At the same time, the Board approved Meyer L. Abrams, M.D. (Willingboro) and Henry J. Mineur, M.D. (Cranford) to serve as alternates.

Effective as of 1 November 1968, the Board appointed Mr. Edward F. Meara, III of Trenton, as Legislative Consultant to the Society, to render the following basic services:

1) To be present at each session of the New Jersey Legislature and to follow closely the progress of legislation identified as of particular concern to the Society;

2) To maintain close contact with the two members of MSNJ officially designated as the legislative educational representatives of the Society, to advise and guide them in discussions with the leaders and key members of the Legislature concerning bills of special importance, and to keep them informed concerning the status of such measures and the means best suited for attaining the Society's objectives with reference to them; and

3) To work under the direction of and in close cooperation with the Executive Director, acting for the Council on Legislation, to whom the Legislative Consultant will make periodic reports as indicated.

Specialty Societies

In furtherance of its established policy, the Council on Legislation invites each specialty

society to send an official representative to all Council meetings. In a letter addressed to all MSNJ's Official Intermediaries with New Jersey Specialty Societies early in the current legislative year, the Chairman of the Council declared: "It is our desire in the Council on Legislation to have the benefit of the thinking of specialty societies concerning proposed legislation affecting the specialty fields. It is also our desire to do all that we can to keep the specialty societies informed concerning the thinking of the Council and its recommendations regarding proposed legislation. For this reason, we regularly invite official representatives of specialty societies to attend our meetings. We hope that they will continue to do so regularly." Copy of the advance agenda is sent to those representatives who indicate their intention of attending an announced meeting.

Federal Legislation

It is the traditional and well established procedure of the Council to be guided on the national legislative front by the positions and recommendations of the American Medical Association. Among the many significant measures introduced in 1968, the Council gave particular attention to the proposed Child Health Act (S-3323) which would have restricted the payments for drugs furnished under Social Security and welfare programs, and granted to the Secretary of Health, Education and Welfare the unfettered authority to dictate the method of payment of fees to be allowed for health services rendered under these programs. This bill failed to pass.

The advent of the new administration has witnessed the introduction of twenty-three bills that would include chiropractic services under Part B of Medicare, and of a bill that provides that payment for physicians' services under Part B shall be on the basis of a "reasonable allowance" rather than the usual and customary fee. These bills have not moved at the present time.

Current State Legislation

In the afternoon of 14 January 1969, the 193rd (1969) session of the State Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members (31 Republicans, 9 Democrats) and the Assembly has a total of 80 members (58 Republicans, 22 Democrats). By means of official legislative bulletins, the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, county society secretaries, and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Active support . . . all-out support for the measure

Active opposition . . . all-out opposition to the measure

Approved . . . commended as satisfactory, but not actively supported

Disapproved . . . rejected as unsatisfactory, but not actively opposed

No action . . . considered, but not regarded as significant or relevant to the proper interests of the Society

All measures thus marked (*) are identical with bills of last year — or preceding years — and the Society's position concerning them is the same.

S-37 —To authorize the Trustees of the New Jersey College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *NO ACTION*

*S-39 —To provide penalties for first, second and third offenses of violations of the narcotics drug act. *APPROVED*

S-45 —To permit county appropriations for the benefit of brain-injured persons to defray expenses incident to diagnosis, treatment and training. *APPROVED*

*S-66 —To prohibit littering of waterways and adjacent shores and beaches and to regulate marine toilets. *APPROVED*

*S-75 —To provide for the establishment of a Medical and Dental College of South Jersey by Rutgers University. *APPROVED*

S-149—To require the fluoride contents of any public potable water supply to be maintained between eight tenths and one and two-tenths milligrams per liter enforced by the Department of Health. *APPROVED*

*S-152—To provide for increases in maximum weekly workmen's compensation benefits for permanent partial disabilities, increases in funeral allowances, free choice of physician, a Board of Workmen's Compensation Appeals and other changes. *APPROVED*

*S-153—To provide for the licensing and registration
A-121—of electrologists by the Board of Medical Examiners. *APPROVED*

*S-157—To permit the Board of Medical Examiners to grant a license for practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. *ACTIVE OPPOSITION,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes, or to those of other states whose licensees New Jersey accepts on a basis of reciprocity.

*S-165—To repeal the tax on gross receipts of unincor-
A-124—porated businesses. *APPROVED*

*S-177—To provide for civil commitment of drug ad-
A-23 —dicts. *APPROVED*

*S-179—To provide that any applicant for a license to practice medicine and surgery who, in addition to other required proofs necessary to be admitted to examination, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *DISAPPROVED,* because it would abrogate the present discretionary powers of the Board on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

*S-185—To provide increased penalties for violation of the narcotics drug act and to provide that such penalties shall not be remitted nor shall any person sentenced thereunder be eligible for parole. *APPROVED*

S-187—To require every district and regional board of education to appoint an advisory committee on narcotics for each of the high schools in a school district, to make studies and advise what measures should be taken to eliminate narcotics from such schools. *APPROVED*

*S-188—To provide for the distribution of a supply of fluoridated tablets by the Department of Health where applied for by a Board of Health when any child under 9 shall request same on an application signed by the parent or guardian of the child. *DISAPPROVED,* because it is impractical of implementation, since there is in New Jersey only one county board of health established by statute — Hudson. Moreover, the fluoride tablets that are to be made available under the terms of this legislation will not be prescribed or ordered by a licensed physician but upon the request of a parent. This fact is in conflict with the Society's position of disapproving self-diagnosis and self-treatment on the part of the public.

*S-189—To provide that no hospital or medical service corporation or insurance company shall be entitled to be subrogated to any claim of an insured as against any third party other than the employer of the insured or the employer's carrier or any hospital or physician's lien except payments made under the Workmen's Compensation Law. *DISAPPROVED,* in support of the position of Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey.

*S-192—To provide for public representation on all professional boards. *ACTIVE OPPOSITION,* because professional unqualified lay members would encumber the boards, with no appreciable advantage to the public.

*S-198—To authorize the Board of Medical Examiners to permit municipal hospital employees who hold M.D. or D.O. degrees to practice in the hospital without a license. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

S-209—To remove restrictions against the practice of medicine by persons in the employ of a municipal hospital who hold M.D. or D.O. degrees, and where a physician is duly licensed in any foreign country where requirements for licensing are not substantially lower than New Jersey and while teaching and not in private practice. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

S-210—To restrict in State Institutions the availability of a patient's medical record for public use except by his consent or upon court order. *APPROVED*

S-211—To authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine. *DISAPPROVED,* pending consultation with the sponsors of the bill and medical schools, because we do not find this bill and its terms and elements completely clear and because it has very vital application to the standards of medical care and the public interest.

*S-222—To authorize the chief executive officer of a state or county institution for the mentally ill or retarded or of a state or county penal or correctional institution to give consent for treatment of incompetent patients or inmates under 21. *APPROVED*

*S-246—To exempt law and medical libraries of attorneys and of physicians and surgeons from assessment and taxation as personal property used in business. *APPROVED*

S-275—To require medical service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employee covered under contracts. *NO ACTION*

S-276—To require hospital service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employee covered under contracts. *NO ACTION*

*S-301—To license and regulate medical care facilities; transfers powers and duties to the Department of Health from the Department of Institutions and Agencies; amends the act concerning hospital service corporations and hospital serv-

ice plans and reconstitutes the board of trustees of the Hospital Service Plan to limit representation of the health profession and health care institutions to one-third. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

*S-337—To provide for the construction of Community Mental Health Center to be managed by the New Jersey College of Medicine and Dentistry. *APPROVED*

*S-350—To authorize the school medical inspector to accept the report of physical examination of a pupil by his treating physician. *ACTIVE SUPPORT*

*S-356—To provide a penalty for operation of a motor vehicle while under the influence of marijuana. *APPROVED*

*S-365—To provide for the confidentiality of information and data secured by and in possession of hospitals or extended care facility utilization review committees. *ACTIVE SUPPORT*

*S-366—To provide that medical records or photographic reproductions shall be retained by a hospital for seven years following the most recent discharge of a patient or until the confined person reaches age 23, whichever is later; to require retention of a discharge summary sheet for 20 years and x-ray films for 5 years. *APPROVED*

S-387—To define "resident" in the act regulating rest homes for sheltered care and to provide that nothing in the act shall prevent care of residents in emergency cases where the attending physician certifies that continued care is in the best interest of the resident. *APPROVED*

S-404—To provide that any person who advertises, sells or offers any person any compound intended for household use which contains poisonous ingredients and does not label such package clearly is a disorderly person. *APPROVED*

S-408—To provide that the Board of Trustees of the New Jersey Medical and Dental College shall consist of 9 instead of 7 members. *NO ACTION*

*S-413—To provide that the State Sanitary Code shall not contain any regulation which requires or directs the mandatory fluoridation of any public potable water supply. *APPROVED*

*S-424—To provide that any applicant for a chiropractic license must have completed no less than one and one-half years of study in accredited school or college of arts and sciences before commencing study in the approved school of chiropractic. *NO ACTION*

*S-427—To provide for establishment of regional evaluation centers for mentally retarded, physically handicapped, emotionally disturbed, socially maladjusted and multiple handicapped children. *NO ACTION*

S-439—To permit any person, including his insurer,
A-327—to make payment to, or on behalf of, a potential plaintiff for losses or expenses resulting from any accident, without admission of liability. *APPROVED*

S-489—To authorize hospital service corporations to include such health care services or supplies as are approved for inclusion in their contracts by the Commissioner of Banking and Insurance. *DISAPPROVED,* because this bill would enable hospital service plan to provide medical services, a result which is invasive of the historical function of the medical service corporation and has dangerous implications to the private practice of medicine.

S-492—To permit employers of Public and School Employees Health Benefit Plan to extend benefits of fully paid health insurance to their employees after they retire. *APPROVED*

S-493—To permit public employers to extend benefits of fully paid health insurance to their employees after they retire. *APPROVED*

S-505—To authorize a bond issue, afer referendum of $100,000,000 to provide State grants-in-aid for capital construction and modernization of voluntary non-profit community hospital and related medical facilities. *NO ACTION*

S-540—To provide for appointment of 2 licensed practical nurses to the New Jersey Board of Nursing. *APPROVED*

SJR-10—To create a commission to study and evaluate the effectiveness of existing laws, rules and regulations relating to the practice of all branches of the healing arts dealing with any part of the mind or body of human beings. *APPROVED*

SR-6 —To create the "Senate Special Committee on the Training of General Practitioners of Medicine and Dentistry" to inquire into what steps the State medical and dental colleges have taken to comply with legislation to prepare students for general practice in these professions.

A-3 —To require licensing of the practice of medical technology; to create a Medical Technology Advisory Committee. *DISAPPROVED,* because there is currently in New Jersey and across the nation a serious ancillary personnel manpower shortage. The excessively proscriptive provisions of Sections 6, 7, and 8 of this bill will only serve to aggravate and intensify the dearth of qualified personnel and will have an untoward effect upon the delivery of quality health care.

*A-21 —To authorize persons who successfully complete a course of training in a public or private hospital or who have assisted physicians for not less than two years to carry out limited ancillary technical procedures in assistance of physicians. *ACTIVE SUPPORT*

*A-23 —To provide for civil commitment of drug ad-
S-177—dicts. *APPROVED*

A-70 —To allow residents of boarding homes for sheltered care or rest homes to receive nursing care upon certification of the attending physician. *APPROVED*

*A-105—To provide that alcohol in excess of 0.05% but less than 0.10% in a motor vehicle operator's blood shall not give rise to a presump-

tion that his driving ability was or was not impaired by consumption of alcohol. *APPROVED*

*A-106—To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of an industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

*A-107—To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

A-108—To authorize establishment of regional air pollution control districts. *APPROVED*

*A-114—To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

A-120—To provide for commitment of convicted sex offenders; to provide for physical and mental examinations and special treatment; to provide for payment of maintenance costs by the treated person or his family. *APPROVED*

*A-121—To provide for the registration and licensing
S-153—of electrologists by the Board of Medical Examiners. *APPROVED*

*A-124—To repeal the tax on gross receipts of unincor-
S-165—porated businesses. *APPROVED*

*A-126—To increase penalties for violations of the narcotic drugs act and to provide for examination of suspected narcotic and drug addicts by two qualified physicians upon court initiative or request of counsel for the defendant. *NO ACTION*

A-137—To authorize gifts of all or part of a human body after death for advancement of medical science or replacement or rehabilitation of diseased or worn out parts or organs. *APPROVED*

A-145—To authorize hospital service corporations to include health care services or supplies as are approved for such inclusion in their contracts by the Commissioner of Banking and Insurance. *DISAPPROVED,* because this bill would enable hospital service plans to provide medical services, a result which is invasive of the historical function of the medical services corporation and has dangerous implication to the private practice of medicine.

*A-170—To provide that no municipality shall treat its water supply with fluoride unless first authorized by the legal voters. *APPROVED*

A-180—To delete from the act concerning assistance for dependent children that provision which provides that a determination of a right to financial assistance by reason of unemployment or underemployment of parents shall not constitute such persons as eligible for coverage under the "New Jersey Medical Assistance Act." *APPROVED*

A-181—To delete from the public assistance act that provision which provides that any grant of old age assistance shall not make recipients thereof eligible for coverage under the "New Jersey Medical Assistance Act." *APPROVED*

A-188—To authorize hospital service corporations to issue additional health care services as approved by the Commissioner of Banking and Insurance. *DISAPPROVED,* because this bill would enable hospital service plans to provide medical services, a result which is invasive of the historical function of the medical services corporation and has dangerous implications to the private practice of medicine.

A-189—To authorize medical service corporations to issue benefits for health care services, other than medical services, as approved by the Commissioner of Banking and Insurance. *DISAPPROVED,* because the medical service corporation was founded under the auspices of The Medical Society of New Jersey. Its sole function is to provide benefits for medical services and it should restrict itself to this type of service. "Other health care services" might include services not medical in nature.

A-200—To provide for licensing, inspection, and regulation of medical care facilities, to create a Commission on Hospital Care and Related Services and to provide for enforcement. *NO ACTION*

A-214—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-232—To provide that no dog or other animal caught and detained shall be sold or otherwise made available for the purpose of experimentation. *DISAPPROVED,* because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

*A-271—To establish a Division of Narcotic and Drug Abuse Control in the Department of Health. *APPROVED*

*A-272—To provide that prepackaged meat shall be in containers which are colorless and transparent on all sides. *NO ACTION*

A-279—To increase maximum weekly Workmen's Compensation benefits for death, permanent total and temporary disability to $90; to increase maximum weekly benefits for permanent partial disability to $45 and to increase number of weeks for enucleation of an eye, 25% increase in amputation awards and other changes. *NO ACTION*

*A-285—To provide that no hospital emergency receiving room shall be open for treatment unless there is in attendance at least one person on the staff who speaks English and is capable of interpreting same in the language of the licensed medical practitioner in charge of such room. *APPROVED*

A-322—To repeal the gross receipts excise tax on unincorporated businesses. *ACTIVE SUPPORT*

A-327—To permit any person, including his insurer, S-439—to make payment to, or on behalf of, a potential plantiff for losses or expenses resulting from any accident, without admission of liability. *APPROVED*

A-328—To provide that the name of a corporation organized under "The Professional Service Corporation Act" shall contain a name descriptive of the type of professional service in which it is engaged. *APPROVED*

A-358—To establish motor vehicle offenses for driving while under the influence of intoxicating liquor and while ability to operate a motor vehicle is impaired by consumption of alcohol, and to permit the Superintendent of State Police to issue orders from time to time to halt at random any vehicle and request the operator to submit to an analysis of his blood for alcohol and to provide penalties. *DISAPPROVED,* the medical aspects of this bill are proper, but the enforcement procedure and the penalties prescribed are an abridgement of the rights of a citizen.

A-359—To provide for a penalty of imprisonment for 30 days for the first offense of operating a motor vehicle while under the influence of alcohol or drugs or where an owner lets another under such influence operate a motor vehicle. *DISAPPROVED,* the medical aspects of this bill are proper, but the enforcement procedure and the penalties prescribed are an abridgement of the rights of a citizen.

A-371—To provide that any person employed in a county narcotics clinic as a psychiatric social worker and/or social worker in a narcotics clinic who assumes responsibility of the Director in his absence and attends meetings in his place and who has trained and instructed others and worked for a clinic for 18 months and with the Narcotics Commission for 5 years shall be eligible for appointment as Assistant Director. *DISAPPROVED,* because the person holding the position of assistant director of a county narcotics clinic should be a physician.

A-390—To prohibit sales of motor vehicles and motorcycles which exceed prescribed noise standards. *NO ACTION*

*A-392—To provide for determination of potable water standards by the Department of Health; to provide for hearings prior to adoption of such standards; to prohibit construction of any new water supply system, pumping station or water stoppage facility until the sanitary engineering features of plans and specifications have been reviewed and to provide for supervision of all water supply systems with respect to quality, protection, and maintenance of adequate volume. *APPROVED*

*A-394—To permit the Department of Health to exempt incinerators which by type and size, in its opinion, should not be subject to the licensing requirements of the solid waste disposal act. *APPROVED*

*A-446—To require ophthalmic dispensers to hold a high school diploma or equivalent in order to qualify for examination and certification. *APPROVED*

A-448—To delete the December 31, 1969 termination date applicable to prohibitory provisions concerning the practice of medicine and surgery from which exemption may be granted to doctors employed on the medical staff of a state agency. *DISAPPROVED,* because of the indefinite extension of time which this bill effects.

*A-468—To provide that licensed psychiatrists or psychiatric social workers within a community health center shall be entitled to reimbursement for services performed under any policy of group accident, group health and group accident and health insurance. *DISAPPROVED,* insofar as licensed psychiatrists and psychologists are concerned, these bills are unnecessary because these individuals are already entitled to reimbursement for eligible services to eligible subscribers which they render under the scope of their professional licenses. As regards psychiatric social workers these bills are undesirable because such workers are not licensed or in any other way authorized to serve as dispensers of health care services, and the bills do not include a definition to indicate what actual work a psychiatric social worker is permitted to perform.

*A-471—To provide licensed practicing psychologists, psychiatrists or psychiatric social workers within a community mental health center with reimbursement for services performed under any policy of accident and sickness insurance. *DISAPPROVED,* for the same reasons as set forth in A-468.

*A-473—To provide that benefits under any policy of accident and sickness shall not be denied any individual when services are performed by a licensed practicing psychologist, psychiatrist or psychiatric social worker. *DISAPPROVED* for the same reasons as set forth in A-468.

*A-479—To provide for control and abatement of noise, to create a Noise Control Council in the Department of Health; to define "noise" as "unwanted sound," and excludes all aspects of employer-employee relationship as to health and safety hazards. *APPROVED*

*A-518—To provide that no dog or other animal caught or procured shall be made available for the purpose of experimentation. *DISAPPROVED,* because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-520—To delete protective helmets from the act requiring certain equipment for motorcycle operators and passengers. *DISAPPROVED,* because protective helmets are a very necessary safety device for operators and passengers of motorcycles.

*A-538—To regulate and control the sale and distribution of drugs, medicines, and poisons and the practice of pharmacy. *NO ACTION*

A-589—To create a Governor-appointed commission known as the Rutgers, South Jersey Medical and Dental College Planning Council, to choose a site for a medical-dental school in South Jersey. *ACTIVE SUPPORT*

Approved with commendation to the Chairman, members of the Council, and the Legislative Analyst for a job well done **(page 418)**

Supplemental Report #1

At its 20 April meeting, the Board of Trustees considered and acted upon recommendations from the Council's meeting of 17 April. The Council therefore offers this Supplemental Report #1 covering the bills dealt with since the compilation of its annual report.

Report on S-211

S-211—To authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine.

The Council originally took a position of "*DISAPPROVED,* pending consultation with the sponsors of the bill and medical schools, because we do not find this bill and its terms and elements completely clear and because it has very vital application to the standards of medical care and the public interest" on this measure. At their 17 April meeting, after consideration of material before them and further discussion on S-211, they reaffirmed their position of "disapproved" for the following reason:

DISAPPROVED, as undesirable and unnecessary because interns and residents are presently not required to hold licenses as physicians and surgeons to serve in hospitals in New Jersey. No licenses should be granted to other than demonstrably qualified persons who have met the requirements of the Medical Practice Act.

Current State Legislation

The following list presents the official position of MSNJ regarding additional bills currently in the Legislature. Those measures thus marked (*) are identical with bills of last year — or preceding years — and the Society's official position concerning them is the same.

*S-481—To provide for licensing of any applicant for a license to practice medicine and surgery who can establish he has been examined and licensed by certificate of the National Board of Examiners for Osteopathic Physicians and Surgeons. *APPROVED*

*S-561—To define, under the Hazardous Substances Labeling and Sales Act, the term "label" as applied to an unpackaged article; the term "misbranded package" to include a child's toy and to provide a definition for "banned hazardous substance." *APPROVED*

S-567—To increase maximum weekly workmen's com-
A-279—pensation benefits to $90 for permanent total and temporary disabilities and death benefits, to increase permanent partial disability weekly benefits to $45, to provide increased benefits for amputations and enucleation of the eye; to provide for appointment of judges of compensation by the Governor with advice and consent of the Senate, to provide for lump sum settlements and other amendments. *NO ACTION*

*S-570—To provide hospital, medical, surgical and major medical expense benefits for State employees and their dependents and to permit a refund from the State Health Benefits Commission to an employee of an employer other than the State whose spouse is also an employee of an employer other than the State where the spouse is enrolled as a dependent and the employee is required to pay the full cost of dependent coverage. *NO ACTION*

S-586—To require trustees of the New Jersey Medical and Dental College to appoint employees in accordance with provisions of Title 11 Civil Service. *NO ACTION*

S-599—To provide that in approving dental x-ray technology the board shall take into consideration standards adopted by the American Dental Association for training dental hygienists and dental assistants. *APPROVED*

S-641—To provide for issuance of certificates for the operation of air pollution control equipment or apparatus in dwellings where such can be operated without violating any pertinent codes or regulations and if such equipment incorporates the latest advances in control technology. *APPROVED*

S-642—To define "area" in the Air Pollution Emergency Control Act to mean only that portion or portions of the State described in the Governor's air pollution emergency declaration. *APPROVED*

S-643—To authorize the Clean Air Council to establish an *ad hoc* joint technical committee of 7 members with power to promulgate rules and regulations. *DISAPPROVED,* because there is no evidence at the present time that the control now exercised by the Department of Health is not satisfactory and that the personnel of this proposed *ad hoc* committee would be as well informed in the control of air pollution as is the Department of Health.

S-646—To provide for the establishment of air pollution control commissions in the counties. *DISAPPROVED,* because there is no evidence at the present time that the control that is now exercised by the Department of Health is not satisfactory and that the personnel who would control these committees would be as well informed in the control of air pollution as the Department of Health. Moreover, the prevailing unified control would be jeopardized.

S-661—To put the Division of State Medical Examination in the Department of Health, removing it from the Department of Law and Public Safety and to provide for supervision by the Commissioner of Health in place of the Attorney General. *DISAPPROVED,* because by far the greatest part of the work of the Office of the State Medical Examiner lies in the area of law enforcement and police investigation and is more proper to the Department of Law and Public Safety than to the Department of Health.

S-669—To establish the "New Jersey Pure Water Bond Act" authorizing issuance of bonds, after referendum, in the amount of $304,850,000 for water supply and water treatment facilities. *NO ACTION*

S-689—To exempt from the restrictive provisions of the New Jersey Industrial Home Work Law those persons homebound because of advanced age, physical or mental disability, injury or illness; to provide for medical certification of ability; to establish that the N.J. Rehabilitation Commission, N.J. Commission for the Blind or other agency recommends employment; to authorize the Commissioner of Labor and Industry to promulgate rules and regulations and other amendments. *APPROVED*

S-721—To require the Commissioner of Institutions and Agencies to establish a program of education in the legal, sociological, medical and psychological aspects of the prevention and control of drug abuse and narcotic addiction to be administered by his Department. *APPROVED*

S-725—To provide for continuation of facilities to educate handicapped children through the summer months; to define "atypical pupils" to include those classified as handicapped and include pupils of ages 3 through 20 years. *APPROVED*

S-727—To permit subscribers to medical service corporations the benefit of physical therapy services performed by a registered physical therapist elsewhere than in a hospital. *APPROVED*

*A-127—To define a "depressant or stimulant drug" to include any hallucinogenic drug, including d-lysergic acid diethylamide (LSD), n-n-dimethyltryptamine (DMT) psilocybia, mescaline, peyote, bufotenin, epena, parua, ayahuasca, yage, caapi, amaneta muscaria and other substances; and to provide penalties. *APPROVED*

A-270—To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefore. *APPROVED*

A-372—To provide that when an applicant for a nurse's license has been previously licensed or registered under the laws of another state, territory, possession of the United States or any foreign country, the examination shall be limited to subjects prescribed by the New Jersey Board of Nursing and not covered in the initial examination. *DISAPPROVED,* in support of the position of the State Board of Nursing and because it would impair the uniform standards for licensing nurses in New Jersey.

*A-582—To establish a Division of Medical Care Facilities within the Department of Health with comprehensive responsibility for the development and administration of State policy with respect to hospital and related medical care services in all public and private institutions. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

A-614—To provide that the requirement of a certificate under the act concerning regulation and certification of x-ray technicians shall not apply to licensed dentists and persons who operate, under a licensed dentist's direct supervision, only x-ray equipment designed for dental radiographs. (Amends A-660 of 1968 — approved) *APPROVED*

A-618—To provide that nothing contained in the Workmen's Compensation Law shall be construed to render immune from liability under the common law or otherwise, on account of an injury or death, any person who at the time of the injury or death was in the employment for the same employer as the person injured or killed and who engaged in the practice of medicine. (Companion to A-633 of this year.) *DISAPPROVED,* because it discriminates against doctors of medicine among licensed practitioners of the healing arts and does not restrict the liability to acts of professional service.

*A-628—To exempt over-the-counter drugs recommended and generally sold for the relief of pain, ailments, distresses or disorders of the human body from the Sales and Use Tax Act. *APPROVED*

A-633—To provide that nothing contained in the Workmen's Compensation Law shall be construed to render immune from liability under the common law or otherwise, on account of an injury or death, any person who, at the time of the injury or death, was in the employment of the same employer as the person injured or killed and who engaged in the practice of medicine, surgery, dentistry or chiropractic. (Companion to A-618 of this year.) *APPROVED*

A-638—To require disclosure of generic and brand names on prescription drugs, compounds and medicines. *APPROVED*

A-657—To require all passenger automobiles to be equipped with ventilation systems while the motor is running effective July 1, 1970, of a type approved by the Director of Motor Vehicles. *APPROVED*

A-663—To increase penalty for violation of health ordinances to imprisonment for 90 days or a fine of $1,000 or both. *NO ACTION*

*A-664—To establish presumptions in certain illnesses of firemen and policemen. *DISAPPROVED,* because it involved diagnosis by legislative enactment rather than by medical investigation.

*A-670—To include carbon tetrachloride in the phrase defining "glue." *APPROVED*

*A-677—To establish penalties for violations of the motor vehicle laws when a person is convicted of violations while under the influence of alcohol or narcotic or habit producing drugs. *NO ACTION*

A-688—To provide that if perishable items are in package form they shall contain a label in 12 point type which shall read "do not use after" followed by a date. *APPROVED*

A-690—To provide that grounds for refusal to grant or suspend or revoke licenses to practice medi-

cine, surgery or chiropractic shall include violations of any provision of the act or any rule, regulation, code of ethics promulgated by the Board of Medical Examiners or where a practitioner is found guilty of unprofessional, dishonorable or unethical conduct. *DISAPPROVED,* because it is the proper function of the State Board of Medical Examiners to enforce the rules and laws governing the practice of medicine, and it is the province of the profession of medicine itself to enforce conformity with principles of ethics and standards of professional conduct.

A-703—To increase the maximum and minimum penalties for violations of health ordinances. *NO ACTION*

A-708—To provide for dating of frozen foods; to require the Department of Health to promulgate standards for maximum lengths of time various types of foods may be kept frozen without damage to healthfulness, nutritive value or palatability. *NO ACTION*

A-713—To provide that no person may fabricate or sell eyeglasses or sunglasses unless fitted with plastic or glass lenses which are tempered and case hardened with minimum thickness of 2 millimeters, and to prohibit cellulose nitrate or other highly flammable frames. *APPROVED*

*A-758—To provide that the term "depressant or stimulant drug" shall include any hallucinogenic drug, to prohibit possession of such drugs by unauthorized persons. *APPROVED*

A-776—To authorize the Commissioner of Health to establish and operate community health centers under the "Community Health Center Demonstration Act." *NO ACTION*

A-811—To provide that no commercal licensee shall collect blood for transfusions and pay a consideration therefor unless, prior to phlebotomy, the donor is examined by a physician. *APPROVED*

A-819—To establish the Clean Water Treatment Bond Act providing for a bond issue of $20,000,000 for controlling and eliminating pollution of streams, lakes, waterways, bays and other tidal and surface waters by acquiring and constructing public water treatment facilities. *NO ACTION*

A-820—To provide for 9 in place of 5 nursing home administrators on the Nursing Home Administrators Licensing Board, two of whom shall be administrators of governmentally operated nursing homes and two shall be from non-profit homes for the aged with licensed infirmaries. *NO ACTION*

A-842—To appropriate $100,000 to the State Mosquito Control Commission for transfer to the Agricultural Experiment Station for mosquito control research. *NO ACTION*

ACR-65—To create a commission to study the use, sources, and trafficking in narcotic and hallucinogenic drugs in high schools, colleges, and universities. *APPROVED*

Approved (page 418)



Scientific Section in Session

Medical Services

Louis K. Collins, M.D., Chairman, Glassboro

(Reference Committee "E")

The Bylaws state: "The function of the Council on Medical Services shall be to study and evaluate matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, to investigate matters pertaining to the economic and social aspects of medical care, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of medical service." The Board of Trustees has added to the functions of the Council on Medical Services overall responsibility to study and provide recommendations concerning (a) all aspects of the Medicare and Medicaid programs as they operate or will operate in New Jersey; and (b) the maintennce of quality medical care.

In fulfilling these assigned functions, the members of the Council on Medical Services have been very active in the past year. The following report will give in detail the work of the Council during the past year.

Physicians' Fees in Workmen's Compensation

Once again considerable time was devoted to the manner in which the State is arbitrarily reducing physicians' fees for medical services rendered to State employees under the Workmen's Compensation Act. Legal Counsel explored the area of contention with the Division of Workmen's Compensation and reported that New Jersey law provides that where an employer fails or neglects to secure the services of a physician, the employee may obtain such services and his employer is bound to pay usual fees and charges prevailing in the same community for similar services. The State has been utilizing a fee schedule based on the "Blue Shield 500." When a physician can establish that the usual charge in the community for the service he rendered is above the fixed rate, the State will pay the prevailing fee. Since it may be difficult for the physician to establish that his fee is the prevailing fee, he may be faced with a reduced payment. The only redress at this point is in the courts of New Jersey, where the burden of proof is on the physician.

In view of the foregoing, we prepared a statement with the approval of the Board of Trustees, that declared in essence the following:

> . . . "The physician who will not settle for less than his usual and customary fee should not treat a State employee for a compensation related injury or illness, or should in the alternative, prior to instituting treatment, inform the patient that he will hold him personally accountable for the difference between the State fee schedule and his usual and customary charges."

The entire statement appeared in the January 1969 issue of *The Journal.*

Utilization of Physicians' Services Under Part B of Medicare

The Bylaws of The Medical Society of New Jersey mandate that all complaints against members and all fee disputes shall be processed through the Judicial mechanism. (Chapter VII, Section 5, Section 6.) The 1968 House of Delegates in considering complaints by the fiscal intermediary concerning utilization of physicians' services under Medicare declared:

> ". . . (2) That the fiscal intermediary be advised that it should file a complaint with the proper committee of the component society — utilization or judicial committee — when it feels (after due consultation with its medical consultants and advisors) that such action is indicated."

The fiscal intermediary appeared before the Council and requested their endorsement of certain utilization guidelines. After studying this entire area in minute detail, it was the considered opinion of the Council that to state that a man has been a patient more often than is necessary and has billed accordingly is, in fact, to question his ethical deportment and the propriety of his bill. We there-

fore *recommended* with the approval of the Board of Trustees that:

1) When the Medicare carrier, after due consultation with its medical advisors, feels that a question of professional conduct or ethical deportment is at issue, it be advised to process its complaint through the judicial mechanism as the proper agency under the Bylaws of MSNJ (Chapter VII).

2) MSNJ not endorse Prudential's preparation of guidelines, nor encourage Prudential to prepare them unilaterally.

Approved the following Reference Committee recommendation:

That a special committee be appointed by the President of The Medical Society of New Jersey to investigate this matter afer a suitable sampling of cases is secured from the utilization review committees of the component societies. It is emphasized that such cases are not to include those in which the fiscal intermediary has filed a complaint with the judicial committee of a component society. (page 418)

Specialty Services to Welfare Recipients

The Council received a referral from the Board of Trustees concerning the fees paid to physicians on an arbitrary basis by welfare agencies, regardless of specialty status or the nature of professional services rendered. The same issue was raised by Resolution 7 of the 1968 House which was approved as amended. Resolution 8 of the 1968 House called for the payment of usual and customary fees for services rendered to welfare recipients. As a result, on 5 June 1968, a letter was transmitted to the Commissioner of Institutions and Agencies over the signature of the Acting Secretary of MSNJ. A reply was received a week later from Maurice G. Kott, Acting Commissioner of Institutions and Agencies, to the effect that the matter was under study and that the Society would be contacted in due course and asked to participate in discussions. Since nine months have elapsed with no further response from the Department of Institutions and Agencies, the Council *recommended:*

That the Board of Trustees communicate with Commissioner McCorkle of the New Jersey State Department of Institutions and Agencies, to ascertain what action, if any, has been taken to implement the provisions of Resolutions #7 and #8, as adopted by the 1968 House of Delegates.

Statement on the Delivery of Medical Care Services

The Council considered a statement drafted by the Connecticut State Medical Society concerning the delivery of medical care services and recommended to the Board of Trustees that it be endorsed in principle and that the Connecticut State Medical Society be so informed.

Blue Cross-Blue Shield 65

The Council recommended to the Board of Trustees that it record MSNJ's dissatisfaction with the provisions of the Blue Cross-Blue Shield 65 supplement to Medicare because it favors the hospital outpatient department over the private physician. The Board of Trustees directed the matter to the President of Blue Shield. A reply was received indicating that a new Rider to cover this problem would be available in 1969. The Council notes that such a Rider is now being marketed, and for the present it is satisfied with the action taken.

Title XIX in New Jersey

The Council was notified by the Board of Trustees that Dr. Collins, Dr. Benz, and Mr. Maressa are to act as official liaison in discussions with the Department of Institutions and Agencies relative to Title XIX in New Jersey.

During the course of the year various organizations of the Society were active in suggesting amendments to the proposed Medicaid law. Governor Hughes signed S-850 as amended on 15 January 1969. This legislation embodied two of the elements recommended officially by the Society, they are:

1) Beneficiaries under the program are assured free choice of physicians and hospitals.

2) That physicians are free to administer and prescribe in conformity with their best professional judgement and in accord with their legal responsibility for the welfare of the patients under their care.

There is no provision in the law as to the procedure for processing claims, nor was there established a basis of payment for services rendered under the program.

The Board of Trustees at its December meeting appointed a "Negotiating Committee for Medicaid" consisting of the President, President-Elect, Chairman and Vice-Chairman of the Council on Medical Services, Chairman and Vice-Chairman of the Council on Legisla-

tion, and Drs. Benz, Franzoni, and Ornaf representing the Council on Medical Services. It is brought to your attention that the above-mentioned members representing the Council on Medical Services are drawn from each of the Judicial Districts of The Medical Society of New Jersey.

On 28 January 1969 a public hearing was held by the Commissioner of Institutions and Agencies in behalf of the New Jersey Medicaid Commission. The subject matter was limited to the question of the method of payment of claims for services rendered to authorized beneficiaries under New Jersey's Medicaid Program. Dr. Kustrup, President of The Medical Society of New Jersey presented a statement incorporating the following points:

1) That a qualified insurance carrier be designated to process claims for medical services rendered Medicaid beneficiaries.

2) That payment for physicians' professional services be on the basis of their usual and customary charges.

At the time of the preparation of this report, the New Jersey Medicaid Commission has not announced its decision in regard to the foregoing.

Approved (page 418)

Sub-Committees of the Council on Medical Services

Occupational Health, Workman's Compensation, and Rehabilitation

Joseph A. Lepree, M.D., Chairman, Elizabeth

(Reference Committee "E")

The committee met with Alfred J. Napier, Chief Judge of Compensation of the Division of Workmen's Compensation, and Lawrence L. Arcioni, Executive Assistant to the Director of Workmen's Compensation. Judge Napier requested that the following information be distributed to the members of The Medical Society of New Jersey, and the committee was unanimous in its concurrence:

"Temporary disability is payable to the point where an employee receives the maximum medical benefit to restore him to his former efficiency, or – stated another way – to that point where his condition will no longer improve no matter what medical care is rendered and any disability thus becomes permanent."

In view of the foregoing, the committee advises that:

"The term 'light work' should be used with discretion. Moreover, an explanation should be given as to the specific type of duty permitted, with a clear indication as to whether the physician plans to continue treating the patient. It should also be indicated that the patient still has not reached the maximum benefit of medical treatment."

Once again the issue of the failure of the State to pay treating physicians their usual and customary fees for services rendered to State employees in compensation cases was brought to the attention of the committee. This matter appears in detail in the report of the Council on Medical Services. I wish to include in this report our opinion that the committee feels they have established a firm rapport with Judge Napier and Mr. Arcioni.

It is my pleasure to note that by action of the Board of Trustees, The Medical Society of New Jersey is officially co-sponsoring the Golden Jubilee Symposium of the New Jersey Rehabilitation Commission to be held on 16 April 1969. The chairman of MSNJ's Committee on Occupational Health, Workmen's Compensation, and Rehabilitation was designated the official representative of MSNJ to work with the planning committee for the fiftieth anniversary in preparation for the program.

Approved (page 419)

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

This year we launched our second year of existence with considerable optimism. However, before long the Council seemed to bog down in its goals, and as we approach the closing of this year it appears that little was accomplished. An effort to stimulate the Council and its activities resulted in an invitation to Joseph Baker, M.D., Special Consultant to the AMA Council on Mental Health, to visit us, and this was accomplished at our December meeting. It appeared to be a provocative session but unfortunately with little telling result.

Our special committee reports follow and your attention is drawn to particular items of interest. Primarily, the chairman would note that the attendance of some members of our special committees leaves much to be desired. This observation stimulates the suggestion that the incoming officers might choose to replace some of our stagnant members with some new blood.

In this day it is somewhat disheartening to learn that our Special Committee on Alcoholism, in spite of very active and busy committee members (one with the best attendance record of all) cannot find a project-oriented task that is either challenging or requires their attention. One feels compelled to ask, "Are the members too well informed to see the trees in the woods? And also, shouldn't we ask them to share their knowledge and to spread their work, via some public relations program for the members of the Medical Society?"

The Special Committee on Drug Abuse has introduced a number of provocative reactions and we urge your reading this report with particular interest in the hope that some response to this Committee's attitudes may be elicited.

In the report of the Special Committee on Emotional Disorders of Childhood and Adolescence, several positive accomplishments are delineated that are of particular interest, which require your attention.

The Committee on Mental Retardation gratifyingly accepted our suggestion for an exhibit at the 1969 Annual Meeting, which is worthy of your visiting.

The Special Committee on Seizures has taken definitive action in several areas; we are very hopeful that positive legislation will be enacted governing the matter of reporting of seizures. Other informative items dealing with a definition of the epilepsies, treatment programs, and employability of persons with epilepsy and other convulsive disorders are of considerable interest.

A Special Sub-committee on the Study of New Jersey Mental Health Services has finally come to grips with a basic issue and after reporting their findings to the Council, the Council unanimously decided to submit to the House the following:

Recommendations

(a) That The Medical Society of New Jersey officially declare that the Mental Health Program be removed from the jurisdiction of the Department of Institutions and Agencies, and established as a separate and distinct entity with a licensed physician in charge;

(b) That the Governor be urged to appoint a study commission to peruse and evaluate the means necessary to implement the separation of the Mental Health Program from the Department of Institutions and Agencies and that proportionate representation on this commission be given to The Medical Society of New Jersey.

The foregoing paragraphs (a) and (b) were deleted by action of the House (page 422)

Although at our final meeting we closed with a flourish and thereby left the Council with a more optimistic view, we all recognize that much needs to be done. We sincerely hope we are not judged by the proportion of our production to date, for many of us feel that we have just begun to feel our way and hope for more positive results.

Approved as amended by the House (page 422)

Sub-Committees of the Council on Mental Health

Alcoholism

Henry J. Mineur, M.D., Chairman, Cranford

(Reference Committee "F")

During the past year we discussed projects, goals, and methods of operation of the Committee.

Selden Bacon, Ph.D., Director of the Center of Alcohol Studies, Rutgers, met with us and the Chairman of the Council on Mental Health and informed us of the work of the Center on Alcohol Studies.

Each member of the Committee presented his experiences, philosophy, and practices in dealing with the problems of the alcoholic patient. We agreed to be available for consultation as requested, to initiate no new programs or studies, and to meet to implement referrals from the Council on Mental Health.

Approved (page 422)

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus

(Reference Committee "F")

The Committee met three times during this past year. It completed its survey on facilities for emotionally and mentally ill children and County Medical Society involvement in these facilities, and a summary of the survey results was prepared.

It investigated the problem of "Dyslexia" and prepared a concise position statement on this subject. The statement focuses on the need for medical involvement in the diagnosis and management of this disorder and expresses concern over its being viewed as primarily an optometric problem.

The foregoing paragraph was amended by the Reference Committee to read:

It investigated the problem of "Dyslexia" and prepared a concise position statement on this subject as follows:

Dyslexia is a reading disability which may have many different and possibly overlapping etiologies. The etiology is obscure and complex. Some of the children with this disability may be suffering primarily from ocular malfunction, and their reading symptom may respond to treatment directed toward this malfunction. Others may be suffering from diffuse brain damage or dysfunction, or from various
Approved (page 422)

mental and emotional disorders covering a wide range of diagnostic categories.

Because of the poorly understood nature of the entire field of reading disability and its complexity, it is felt that children with this symptom should have the benefit of a comprehensive diagnostic study, under medical direction. This study would include the contributions of all appropriate disciplines and would include the pediatric, neurologic, psychiatric, and ophthalmologic evaluation of the child.

Children who are examined and treated only from the standpoint of optometric disorders may suffer from the lack of understanding of other factors contributing to their reading disability and from lack of treatment measures directed toward those other factors. One needs to look with caution on all forms of therapy, since there is indication that certain therapies may seem to give good results by their placebo effect or as a consequence of the natural maturation of the child's nervous system. (page 422)

Finally, the Committee initiated a study of special educational facilities for emotionally disturbed children, with particular emphasis on the role and use of the school physician and school psychiatrist in the prevention and management of mental and emotional illness among school children.

Approved as amended by the Reference Committee (page 422)

Drug Abuse

Henry A. Davidson, M.D., Chairman, East Orange

(Reference Committee "F")

Your chairmen and several members of the committee have met with representatives of law enforcement agencies and with representatives of addicts themselves. We have noticed that with the large number of self-help addict groups as well as organizations controlled by other groups and agencies there seems to be considerable overlap in the functions of these diverse groups and some competition among them for private and public funds and attention. We hope that efforts will be concentrated on a small number of such self-help organizations of demonstrated effectiveness and that the further dilution of effort among so many units will thus come to an end.

We have somewhat mixed feelings about the Governor's recommendation for 30 additional State policemen "to perform undercover work in apprehending pushers." This kind of undercover activity is often demoralizing, ineffective, and leads to the development of personal vendettas among the targets of such study. It sometimes results in the development of agents provocateurs, and may lead to public hysteria. We see the need for further study and we realize that gentle and above-board methods of investigation may not always be effective; but we do have reservations about the full scale hunt implied. We endorse the Governor's recommendation of a special corps of trained parole officers and probation officers, and we trust that present methods for qualifying such officers are sound enough to keep pace with the necessary, sophisticated training program.

There is much talk about public education at the high school and adult levels. Certainly there can be no objection to better education. However, some of the educational material seems to be ineffective, either because it makes narcotic abuse seem glamorous or because it overdraws the pictures of the effects of drugs — especially those of the marijuana category. We are impressed by a confusion in the sponsorship, channeling, and content of these well-meant educational efforts. We hope that educational authorities will unite to work out a sound, non-hysterical, and medically-acceptable program and develop a systematic way of presenting it.

Your committee was asked to distinguish between "drug addiction," "pseudo-addiction," and "addictive personality." We believe that it would confuse the public, the legisla-

tors, and the courts to try to set up fine criteria of differentiation. This kind of semantic exercise is best left to the physicians charged with the care of such patients.

We note with interest the increasing utilization of methadone. While we are not unaware of the problem of replacing one addiction with another, we see strong evidence that the addiction to methadone does not produce the destructive "highs" which characterize abuse of opium alkaloids. In view of the discouraging nature of the treatment of addiction, we should welcome any rational and safe method. We recommend that further controlled experimentation be conducted in this area, under responsible physician-supervision.

In general, we have been unhappy to note the increasng de-emphasis of the physician's role in this problem with so much of the work, teaching, and patient-contact and reporting done by social workers, psychologists, clergymen, law enforcement people, and almost every one except doctors of medicine.

Approved with commendation to the Chairman for his excellent report (page 422)



Speakers Platform — First Session, House of Delegates

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

The Committee has welcomed as a consultant James B. Butler, M.D., a representative of the State Department of Institutions and Agencies, who we feel has added much to the Committee's deliberations.

The Committee is now working on a scientific exhibit for the Annual Meeting in Atlantic City this May. The exhibit will feature brain autopsies, the more common errors in metabolism, and chromosomal defects leading to mental retardation.

The Committee also felt it essential that we have a representative from the State Department of Education, and at the last two meetings we have had a pediatrician from the Department of Education, William A Kemick, M.D., in attendance.

Approved (page 423)

Seizures

J. Lloyd Morrow, M.D., Chairman, Passaic
(Reference Committee "F")

The committee held three meetings, and in attendance also were the Executive Director, his Executive Assistant, and various officers.

Reporting of Epilepsy

Subsequent to the receipt of the draft of legislation titled "An Act concerning reporting of epilepsy and repealing Sections 26:5-1 through 26:5-13 of the Revised Statutes," the committee made minor changes in phraseology, which were approved by the Council on Mental Health and resubmitted to the Council on Legislation. It is the committee's understanding that this revised legislation is now in the process of being considered for introduction in the Legislature.

Seizure Disorders

The committee devoted considerable effort and study to the definition and delimitation of seizure disorders, and the following definition was finally accepted:

Definition of the Epilepsies: The epilepsies are disorders of the brain characterized by recurrent sudden changes in consciousness, behavior, sensation, or muscular activity that are beyond voluntary control and are due to episodes of disordered activity of brain cells. The resulting observable seizure is called a fit, attack, or convulsion, and may be of many types, the commonest of which are the grand mal, petit mal, psycho-motor, and focal types — which may occur singly or in combination. Frequently seizures are preceded by a warning or aura and are followed by confusional states of greater or lesser duration. Those seizures disorders without demonstrable cause are called idiopathic or asymptomatic epilepsy; those with known cause are referred to as secondary or symptomatic epilepsy.

Treatment of Seizures

The committee is now in the process of preparing a simple and concise format of treatment to be made readily available on pocket-size cards for all physicians.

Information on Epilepsy

The committee examined literature on epilepsy from national and state sources and was satisfied that a compilation of available literature could be derived from existing sources without necessitating an additional project. However, the committee was unanimous in concluding that it had neither the facilities nor resources for dissemination of such information but must rely upon state and local agencies for expertise in this direction — holding itself in readiness to be of assistance to these agencies on request.

Employability of Persons With Epilepsy

The committee discussed with Jarvis M. Smith, M.D., Director of the New Jersey Rehabilitation Commission, ways and means by which it could assist state agencies in drawing up a plan of action that would insure the controlled epileptic's being given every possible opportunity for gainful employment. The committee agreed to lend its assistance in public relations with physicians — particularly those in industrial fields — to encourage the employment of epileptics in positions where no physical danger is involved.

Involvement of Component Societies

The committee is exploring the possibility of enlisting the aid of the component societies in an evaluation of ongoing treatment programs, public education, and assistance in social and occupational needs of individuals suffering from convulsive disorders. It is hoped that through greater public awareness and the active interest of knowledgeable physicians much can be done to establish this problem in the framework of a healthy society.

Approved with commendation to the Chairman and Committee for their excellent work **(page 423)**

Public Health

John P. Coughlin, M.D., Chairman, Jersey City

(Reference Committee "G")

One of the functions of the Council on Public Health is to act as a conduit between the special committees and the Board of Trustees. The reports of the special committees will give detailed accounts of their activities during the past administrative year and will follow the report of the council.

Mixing Obstetrical and Gynecological Patients in General Hospitals

Representatives of the New Jersey State Department of Health met with the Council to discuss the mixing of obstetrical and clean gynecological patients in general hospitals. There are 19 hospitals participating in this program, with periodic inspection being carried out by the Department of Health. A special committee of the Hospital Licensing Board urged that the inspections be discontinued and that enforcement of established criteria be on an honor basis within the hospital. The Council agreed with the State Department of Health that efforts to relax the criteria should be opposed. Since time was a factor, the Council recommended to the Board that the matter be referred to the Committee on Maternal and Infant Welfare and that authorization be granted to the Committee on Maternal and Infant Welfare to submit its recommendations directly to the Board of Trustees. The final action taken is reflected in the report of the Committee on Maternal and Infant Welfare, which was approved by the Board and transmitted to the Hospital Licensing Board of the Department of Institutions and Agencies.

Subsequently we were informed that regular external inspections will be carried on by the Department of Institutions and Agencies with the assistance of the Department of Health.

Guide for Hospital Perinatal Mortality Study Conferences

The "Guide for Hospital Perinatal Mortality Study Conferences" was prepared by the Special Committee on Child Health and approved by the Council at its January meeting. The Board of Trustees at its February meeting, although commending the Committee on Child Health for its efforts, disapproved the "Guide" as being too detailed and impractical of implementation. This matter was once again discussed at our March meeting, and the Council voted in agreement with the Board's decision for disapproval.

Since the Bylaws of The Medical Society of New Jersey provide that no member of any administrative council shall serve for more than three consecutive terms, I must bid you my farewell. I wish to take this opportunity to extend my deepest appreciation to the members of the special committees and the Council for their diligent efforts and cooperation through the years.

Approved (page 424)

Your Asthma Guide

A newly-released manual on "Asthma" is now available to you through the New Jersey Tuberculosis-Respiratory Disease Association. This practical guide for physicians, was published by the National TB-RD Association in cooperation with the Allergy Foundation of America. The text was prepared by a joint committee of the Allergy Foundation and the American Thoracic Society, the medical arm of the National TB-RD Association.

Copies are available from the New Jersey Tuberculosis-Respiratory Disease Association, 2441 Route 22, Union, New Jersey 07083.

Sub-Committees of the Council on Public Health

Air Pollution Control

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")

The Committee feels that there has been developed a better "climate" of environmental understanding by the following accomplishments of the year:

Publication — Two articles, originating in this Committee, have appeared in *The Journal.*

Data Collection — MSNJ's P.O. Box Number is being published in *The Journal* as a collecting depot for physicians to report cases where air pollution is considered by them to cause or aggravate illness in their patients.

Continuing Stimulation of the County Societies' Air Pollution Control Committees by furnishing them with pertinent material.

Public Hearings — With the Trustees' approval, a member of the Committee spoke on 26 March before the Public Hearing of the Clean Air Council of the New Jersey State Department of Health. The statement covered the following elements:

1. The consideration of preservation of ecologic balance in planning utilization of New Jersey's natural resources. The need to include trained ecologists in such planning and to give heed to their advice will be emphasized.

2. The establishment by the State Department of Health of a Department of Environmental Health within existing and future medical schools, with The Medical Society of New Jersey invited to cooperate.

3. The initiation by the Clean Air Division of a study of daily slides of particulate matter from those areas in the State where the fallout is significant, to delineate the nature of the particulates.

4. The assistance to physicians by the State Department of Health in establishing registries or data centers for the collection of clinical data to establish the deleterious effects of air pollution on the human body.

Approved with commendation to the Committee for its active participation (page 424)



Speaker of the House of Delegates, Dr. Jesse McCall.

Cancer Control

John L. Olpp, M.D., Chairman, Englewood
(Reference Committee "G")

The breast cancer detection program in Bergen County culminated in a breast cancer detection day on 24 April 1968. On this day, 1,124 women visited clinics in 8 hospitals. A total of 1,493 appointments had been scheduled but the inclement weather resulted in 369 absences. In 911 cases, no abnormalities were found. Abnormalities were detected in 213 cases and further examination disclosed 4 malignant tumors — proved at operation. This is an unusually high incidence of cancer.

The cancer abstracts to be submitted to *The Journal* will be of particular relevance to the general practitioner. To this end, Dr. Sylvan Moolten will consult with the appropriate officers of the New Jersey Chapter of the American Academy of General Practice.

Inasmuch as the Committee has been stressing routine sigmoidoscopy, it commends the New Jersey Division of the American Cancer Society for appropriating $495 for the purchase of one MPC Procto-Sigmoidoscopy model to facilitate procto-sigmoidoscopic demonstrations, and also the Bergen County unit of the American Cancer Society for its appropriation to purchase a similar model.

With the approval of the Council on Public Health we *recommend*:

Recommendation

That The Medical Society of New Jersey urge the New Jersey Division of the American Cancer Society, through its Medical Committee, to suggest that each of the county units appropriate funds for the purchase of proctosigmoidoscopy models for the purpose of instructing physicians in performing routine sigmoidoscopies.

Think CANCER — and diagnose cancer early.

Approved (page 424)

Child Health

William J. Farley, M.D., Chairman, Nutley
(Reference Committee "G")

This committee has continued to pursue its activities in the most essential areas of child care. The need to coordinate our efforts in these areas with other state agencies and organizations is recognized.

Child Health Supervision

1) *Emergency Care of the Severely Injured Child*

The preparation of a booklet, presented in a concise yet comprehensive outline form, for rapid reference and use by the emergency-room physician is nearing completion. This committee has conferred with and will receive the cooperation of Dr. Jack R. Karel, Chairman and the Committee on Emergency Care.

Members of this Committee on Child Health have participated in the Training Program for Emergency Room Physicians sponsored by The Medical Society of New Jersey in five hospitals throughout the state during April and May. Lectures on infant and child emergencies were given. It is anticipated that a

companion booklet "Medical Emergencies in Childhood" can be formulated for hospital emergency-room use.

2) *Guidelines For Well Child Supervision*

Although some literature in this area is now available, it is the opinion of this committee that an informative outline for comprehensive child health care would be worthwhile. Standards for adequate care must still be set in Title XIX programs. The Department of Institutions and Agencies charged with the implementation of Title XIX has expressed an interest in such a guideline. Members of this committee will continue to review this work which admittedly is a major undertaking.

School Health

1) *The Duties and Responsibilities of the School Physician*

The committee is aware of the need for an updated and more meaningful delineation of the physician's role in school health services and education. Work in this area will be in collaboration with William Kemick, M.D., Consultant on School Health, State Department of Education, the New Jersey Association of School Physicians, and the School Health Committee of the New Jersey Academy of Pediatrics.

Assistance in this area has been requested for the current revision of "Guidelines for School Health Services" by the Office of Health, Safety, and Physical Education of the State Department of Education. Active participation in this revision is advisable and will be forthcoming from this committee.

2) *Third Post-Graduate Course for School Physicians*

This course has been sponsored annually by the New Jersey Association of School Physicians and will be held on 23, 30 April and 7 May 1969 from 11:00 a.m. to 4:00 p.m. at the Labor Education Center, Rutgers University, New Brunswick. The program this year will be devoted to contractual agreements and school funding, educational approaches to drug abuse, and contact sports in the grade school child and high school athlete.

Dr. Thomas McFarland of this committee has been charged with studying the area of competitive sports for children and has arranged the latter part of this program. Members of this committee have continued to remain active in the NJASP and each post-graduate course has proved to be provocative, of high academic caliber, and well attended.

3) *Standardization of School Health Forms*

This committee recognizes the need for more uniformity of health appraisal and information forms in the many individual school districts in order to facilitate their completion by the physician. Of particular concern is the fact that some school districts do not request of the child's personal physician any information whatsoever concerning the child's medical background or state of health as it relates to the child's educational needs prior to entrance into school. A brief review of the child's birth history, physical, mental, and emotional development assist in the essential early identification of possible handicaps.

Dr. Bernard Millner, of this committee and the Coordinator of Maternal and Child Health, State Department of Health, has presented a more satisfactory form to this committee for use in the schools.

The committee made the following recommendation that was approved by the Council on Public Health: That the Committee on Child Health of The Medical Society of New Jersey approves of and commends the New Health Appraisal Record (Form MCH-7) and recommends that a letter be sent to Dr. Carl Marburger, Commissioner, State Department of Education, and Dr. Roscoe P. Kandle, Commissioner, State Department of Health, urging its distribution to and use by all school districts with particular emphasis on the initial health appraisal of the child entering school.

The Board of Trustees subsequently disap-

proved this recommendation. It was of the opinion this Health Appraisal Record "would involve a great deal of paper work by the school health physician and that it served no real advantage." Further discussion of this matter is contemplated by this committee.

4) *Statement on Dyslexia*

This committee reviewed and approved a statement formulated by the Society's Special Committee on Emotional Disorders of Childhood and Adolescence regarding dyslexia which may be found in its annual report. The Child Health Committee has suggested letters to the State Departments of Education, Health, and Institutions and Agencies expressing our concern in this complex area.

This chairman, as a member of the Advisory Council on the Handicapped of the Office of Special Education, State Department of Education, has repeatedly expressed the opinion that adequate evaluation and identification of these children require the involvement of many medical disciplines including the appropriate guidance in their educational programs. All members of this Society, particularly school physicians, are urged to examine programs for these children in their own communities.

5) *Sex Education*

The committee is aware of complaints by parents directed to the State Department of Education and to local school boards, and again reviewed and discussed the "Guidelines for Developing School Programs in Sex Education" compiled by the State Department of Education. It is of the opinion that this publication promotes a sensible balance in sexuality and human relationship, emphasizing the integration of the program within the total curriculum with appropriate subject matter commensurate with the developmental level of the child and especially active parental involvement in the program.

The committee reaffirms its prior commendation to the State Department of Education, and its support for its efforts.

Poison Control

The committee discussed the new "Palm-n-Turn" safety pill bottle. Dr. Robert Jennings member and past chairman of this committee appeared on the "Today" nationally televised morning show as part of National Poison Prevention Week to explain this safety feature that makes it virtually impossible for a small child to open a pill bottle.

It was recommended that physician members of MSNJ be encouraged to request pharmacists when filling prescriptions to use this new safety bottle.

Perinatal Morbidity and Morality

"A Suggested Guide for the Hospital Perinatal Study Conference" has been completed with the cooperation of the Committee on Maternal and Infant Welfare and approved by the Council on Public Health. The recommendation by the Council that this Guide be used to initiate a statewide program to encourage perinatal study conferences was disapproved by the Board of Trustees "on the basis that it is too extensive and minute in detail to be carried out by the average hospital in New Jersey."

It must be pointed out that the primary intention of this committee was to design a workable and practical guide that would not only include fundamental concepts necessary for an effective conference but would be presented in a well-organized and compact format to enable the busy medical staff in the average hospital more adequately to evaluate and review its perinatal experience, with a minimum of time and effort.

The cooperation of supervisory services and hospital personnel streamlines its preparation. The physician attending a mother or infant resulting in a neonatal death will be required to complete an individual case study form only a few times per year. The case study forms in turn greatly facilitate the summary work sheets for each quarterly conference and for the annual statistical review.

To suggest that those responsible and capable

physicians of this Society who will daily strive to render excellent care to mother or newborn infant in the many fine hospitals of this state are unwilling to assess their clinical experiences and participate in this periodic educational endeavor is not justified.

Recommendation

That The Medical Society of New Jersey sponsor a state-wide program that will include the distribution of "A Suggested Guide for the Hospital Perinatal Study Conference" to the chiefs of the obstetrical and pediatric departments and the administrator of each hospital, requesting that its use in whole or in part be considered in the development of regular comprehensive perinatal conferences. Letters will also be sent to all component medical societies for action by their appropriate committees to encourage individual hospital participation and county-wide programs.

An invitation to approve and cooperate in this program will be extended to the New Jersey Obstetrical and Gynecological Society, the New Jersey Chapter of the American Academy of Pediatrics and the New Jersey Academy of General Practice.

Approved (with the exception of the item and recammendatian cancerning Perinatal Study Canferences — see Resalutian #24, page 404) with special commendatian ta the Chairman and members af the Cammittee for their long haurs af service and the excellent standards and energetic aims of the Cammittee (page 424)

Conservation of Vision

Frank B. Vanderbeek, M.D., Chairman, Paterson

(Reference Committee "G")

The Special Committee on the Conservation of Vision has been active during the past year.

In September of 1968, the Committee conducted the 12th annual Eye Health Screening Program in conjunction with the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Department of Health, the New Jersey Hospital Association, and the New Jersey Commission for the Blind.

The ophthalmologists of the state staffed 85 centers (an increase of 12 centers over 1967).

A total of 11,659 persons were screened — an increase of 1,039 — or 9.7 per cent — over 1967.

5,243 — or 45 per cent — were found to have positive findings; 6,416 — or 55 per cent — were found to have negative findings.

There were 561 or 4.81 per cent tonometry positive findings.

There were 4,536 or 38.9 per cent visual acuity positive findings.

There were 474 or 4.06 per cent external inspection positive findings.

There were 1,041 or 8.92 per cent ophthalmoscopy positive findings.

The Committee believes this annual program to be successful and has recommended that a similar program be conducted next September, and that Dr. Cinotti be reappointed as Chairman of the program.

A number of suggestions were received from the physicians in charge of various centers. They were discussed. As a result of these dis-

cussions, several modifications will be made in the program next year.

The Committee was apprised of the fact that some physicians in charge had conducted the screenings at their offices. Since the New Jersey Hospital Association is one of our co-sponsoring agencies, and has continued to give support to the program, the Committee unanimously adopted the following policy:

That Eye Health Screening Programs be conducted only in hospitals.

Dr. Kler requested a change in the Amblyopia Screening Program operated by the New Jersey Commission for the Blind and endorsed by The Medical Society of New Jersey. The change would permit the appointment of optometrists to the State, County, and Local Planning Committees, along with representatives from other interested groups already approved. Thus, the Central Planning Committee would consist of:

Medical Director, Commission for the Blind — Chairman
Chairman of MSNJ's Committee on the Conservation of Vision
President of New Jersey Academy of Ophthalmology and Otolaryngology
Representative from the New Jersey State Department of Health
Representative from New Jersey State Department of Education
Representative from New Jersey Academy of Pediatrics
Representative from Delta Gamma Sorority
Representative from Lions Clubs
Representative from the State Optometric Society
Representative from State P.T.A.
Representative from Board of Managers, New Jersey State Commission for the Blind
Representative from the School Physicians
Representative from the School Nurses Association
Executive Director, New Jersey State Commission for the Blind
Coordinator for Amblyopia Program

Optometrists will not be used to assist in the Screening.

This change was approved by the Committee and the Committee recommended that the Board of Trustees approve this change.

Recently, we learned of an informal opinion rendered by the Deputy Attorney General assigned to the State Board of Medical Examiners, which declared that an optometrist may legally apply a local anesthetic to the eye and perform corneal tonometric examinations. This opinion created prolonged and rather heated discussion. Finally, the Committee recommended to the Board of Trustees that it take whatever steps are necessary in the protection of the public interest to assure that only licensed medical practitioners and their legally authorized assistants be permitted to use drugs in examining eyes.

The Board of Trustees, on the 29th of January, referred this item to the Society's legal counsel.

The death of Dr. James Shipman was noted and a suitable memorial resolution was prepared and sent to Mrs. Shipman.

Drs. Kler, Cinotti, and Sellitto were selected as a Sub-Committee to prepare an exhibit for the 1969 Annual Meeting.

Mr. Randall Norris, Executive Secretary of the Guild of Opticians, offered the Guild's assistance in publicizing the Eye Health Screening Program. It was felt the Guild could assist us considerably, and Mr. Norris was so informed.

At the suggestion of Dr. Kustrup, the Committee recommended that next year the name of the Committee be changed to: "The Special Committee on the Conservation of Vision, Hearing, and Speech."

Approved with the following Reference Committee recommendation as amended by the House: That the Board of Trustees continue to take whatever steps are necessary in the protection of the public to insure that only licensed medical practitioners and their legally authorized assistants be permitted to use drugs in eye examinations, under the direction of physicians **(page 424)**

Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

As has been our custom in the past, we reviewed, studied, and classified maternal deaths occurring in the past year. There were, however, other matters of importance before the Committee and their disposition is listed below.

Perinatal Mortality

The Committee considered the request of the Committee on Child Health of The Medical Society of New Jersey that we cooperate with them by co-sponsoring the promotion of Perinatal Mortality Study Conferences in New Jersey hospitals. After protracted discussion and perusal of a "Guide for the Hospital Perinatal Mortality Study Conference" prepared by the Committee on Child Health, we voted to recommend adoption of the "Guide" and the concept involved, provided that Form E was deleted. The Committee on Child Health then presented this material, with Form E deleted, to the Board of Trustees.

Mixing of Obstetrical and Gynecological Patients in General Hospitals

A special committee of the New Jersey Hospital Licensing Board submitted a report to the Department of Institutions and Agencies urging that the responsibility for the regular inspection of hospitals under the mixing program in New Jersey and the maintenance of the established criteria be the responsibility of the chief of obstetrical service in each hospital participating in the program, with the outside inspection being the duty of the Department of Institutions and Agencies.

When the Board of Trustees became apprised of this fact, the matter was referred to the Council on Public Health. Since time was of the essence, the Council on Public Health referred the issue to this Committee and authorized us to report directly to the Board of Trustees.

After extensive discussion we voted unanimously to recommend that The Medical Society of New Jersey continue to approve in principle the mixing of obstetrical and clean gynecological patients, provided that all current recommended criteria are strictly observed and that an adequate form of regular external inspection by a competent agency is maintained.

The Board of Trustees approved this position and transmitted it to the Department of Institutions and Agencies. Our proposal was subsequently accepted and incorporated into the mixing program.

Blue Cross-Blue Shield

The problem of the pregnant patient who is admitted to a hospital for an acute medical-surgical condition has been an area of special concern to the Committee since the patient's hospital stay would be limited to the seven days assigned for maternity benefits under the Medical-Surgical Plan/Hospital Service Plan coverage if the patient is admitted with a primary diagnosis of pregnancy. We feel that if the primary reason for admission is medical or surgical, then the seven day limitation should not apply. If the patient does not have an infectious disease, she may be kept on the obstetrical ward. In this case, the condition of the fetus can be carefully observed, and in case of an obstetrical emergency, the patient is in the hospital area where optimum treatment may be obtained. The primary diagnosis should be the admitting diagnosis and the patient may be on the service of the physician treating the primary disease with the obstetrician listed for the obstetrical care.

Dr. Donnelly, President of Medical-Surgical Plan of New Jersey, who discussed this issue with us, stated that these patients, regardless of the complication, can be much more adequately cared for on the obstetrical service rather than one of the other services of the hospital.

Approved (page 425)

Public Relations

John J. Crosby, Jr., M.D., Chairman, Jersey City

(Reference Committee "F")

In fulfilling its function to "evaluate, suggest, and — with approval—carry out programs and projects calculated to further the public relations of this Society," the Council has continued successfully all its regular operations as outlined below:

Continuing Projects

At its reorganization meeting, the Council decided to maintain all the regular continuing projects and procedures of last year, as follows:

1) Publication and distribution of:

(a) *Junior Health Hints* to schools and public libraries

(b) *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies

(c) *Periodic Newsletter* to cooperating agencies/individuals as required

2) Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:

(a) The Eye Health Screening Program

(b) The Annual Meeting

(c) Child Safety Week

(d) Selected official programs and activities

3) Responsibility for bestowal of the Golden Merit Award

4) Responsibility for the press room and press releases at the annual meeting

5) Encouragement of continuance — or establishment — of orientation programs for new members under sponsorship of component societies

6) Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the 1965 House of Delegates

7) Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level.

Community Health Week

The Council was informed that the AMA conducted a national survey and that the states were evenly divided as to whether the observance of Community Health Week should be held in the spring or fall. As a result of these findings, the AMA recommended that the individual state society choose the time most desirable for its state to hold Community Health Week. The AMA will cooperate by being sure that all material prepared by them will be useable at any time of the year.

With this information before them, the Council surveyed all component societies to see if they plan to hold a Community Health Week this year, and if so, when. Twelve counties replied. Of the counties heard from, none was planning to hold a Community Health Week. One county plans to have a "Health Fair" in April; a few others will conduct a diabetes detection program in the late fall.

Golden Merit Award

The 1968 Golden Merit Award was bestowed upon 42 members of the Society, 25 of whom received the award personally in Atlantic City. This brings the total recipients of the Golden Merit Award since its inception in 1957 to 538. Thus far this year, 42 candidates have been nominated by 13 component societies for the 1969 Golden Merit Award. Following the ceremonies this year, the recipients and their families will be guests of the Society at an informal reception, as they have in preceding years.

Approved (page 423)

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

During the year this Committee has emphasized the improvement and updating of emergency medical care in hospitals. In this connection the Committee recommended and the Board of Trustees approved the following:

Hospitals are encouraged to participate in the Hospital Reserve Disaster Inventory Program. In the first crucial hours of a disaster there is no time to wait for outside assistance to arrive. Hospitals in the disaster area will be faced with mounting numbers of casualties and dwindling supplies of critical medical items. United States hospitals seldom maintain large inventories of expendable items. The Division of Emergency Health Services, U.S. Public Health Service, has developed a program to expand community hospitals' stocks of critical medical items to a 30-day level. Each hospital will use the items supplied by the inventory expansion program and at the same time continue its established rate of procurement. This will help assure disaster readiness and will also achieve an automatic rotation of limited shelf-life items.

In view of the growing number of full and part-time emergency room physicians and the prognostication that this type of practice will be on the increase in the future, it is of vital concern to the populace of New Jersey that a Training Program for Emergency Room Physicians be held and that the subject matter be of such nature as is normally recommended for emergency room physicians.

Therefore at the request of the Committee and with the approval of the Board of Trustees, The Medical Society of New Jersey — in cooperation with the New Jersey Department of Health and the Division of Emergency Health Services of the U.S. Public Health Service — inaugurated a Statewide Training Program for Emergency Room Physicians on March 26, to be held in each of the five judicial districts of MSNJ. The State Department of Health and the U.S. Public Health Service have made funds available to finance this project. This will be the first such program in the nation. A complete series of lectures will be given during a two-day period in designated hospitals of the five judicial districts.

The subject matter in all centers will be identical as follows:

Care of Simple Wounds
Management of Multi-system Injury
Treatment of Burns
Resuscitation — including restoration of airway, shock, hemorrhage, and fluid replacement
Cardio-pulmonary Resuscitation
Psychiatric Emergencies
Infant Emergencies
The Unconscious Patient
Cardio-pulmonary Resuscitation

All physicians, residents, and interns in the State will be invited to attend the lectures. There will be no attendance or registration fees.

It is to be noted that all lecturers are from New Jersey. Cooperating organizations supplying the lecturers are the New Jersey Trauma Committee of the American College of Surgeons, the New Jersey Heart Association, the New Jersey Chapter of the American Academy of Pediatrics, the Council on Mental Health of The Medical Society of New Jersey, and the New Jersey Neuro-Psychiatric Association.

The Committee has further recommended that an in-service training program for emergency room physicians be held in every general hospital and that a survey be made in the

State to ascertain the number of full-time emergency room physicians employed in hospitals.

The Chairman has kept the Committee informed as to developments by the Ad Hoc Advisory Committee of the New Jersey State Department of Health, Division of Emergency Medical Services of which he is a member. This committee and its sub-committee are to be the mechanism for developing the best guidance that we in New Jersey can devise for strengthening the first-aid, ambulance, and rescue services. The specific functions of the Ad Hoc Committee will include:

1. Providing advice on design and development of the operating program.

2. Providing advice on design and content of the Inventory and Survey.

3. Offering recommendations on the development of the Statewide Coordinated Plan for Emergency Medical Services and on the interim plan that will precede it.

4. Providing advice on criteria to be used in connection with the Program of Local Project Grants.

5. Providing advice and recommendations about proposed legislation for the regulation of emergency vehicles, vehicle and equipment standards, certification of first-aid personnel, etc., as required under Standard 4.4.11 of P.L. 89-564.

Approved with the recommendation that The Medical Society of New Jersey continue to support the program of training emergency room physicians and paramedical personnel **(page 415)**

Medicine and Religion

Luke A. Mulligan, M.D., Chairman, Fort Lee

(Reference Committee "D")

The Department of Medicine and Religion of the American Medical Association was established in 1961, to promote dialogue between the professions in an effort to improve patient care, and to explore the increasing number of medical and moral issues.

At the Annual Meeting of The Medical Society of New Jersey in May 1968, a resolution was passed by the House of Delegates recommending to the New Jersey Hospital Association that each hospital in New Jersey support a chaplaincy program by providing space and, wherever possible, financial support. In reply (July 1968) the New Jersey Hospital Association agreed to the request of the House of Delegates, and reported having so informed all member institutions.

The program meeting of the AMA Committee on Medicine and Religion was held in June 1968, in San Francisco. The topic discussed was "Organ Transplants." This timely subject created much interest. At a regional

meeting, held in New York in March 1969, chairmen from all the eastern states from Maine to Virginia attended. The program was conducted by Rev. Paul B. McCleave and Mr. Arne Larson, and was interesting and practical in terms of future plans. A new film was shown, "A Storm, A Strife." This showed the need for and the way in which a clergyman and a physician can work together, serving the whole person and the whole family. (This film is available, without charge, to county and state societies.)

It is gratifying to know that activity is taking place in the county societies, and in the individual hospital staff programs.

At a recent meeting of the Bergen County Medical Society's Committee on Medicine and Religion, a suggestion was made to encourage doctors and chaplains serving the individual hospitals, to meet together and institute discussions aimed at (a) a better understanding of each other's ministrations to the patients, and (b) discussing matters of mutual interest. As a result of this meeting, a Department of Pastoral Care of Bergen County was set up, and is functioning well.

Theological Seminary Programs in the future will be administered by the National Committee on Medicine and Religion, in conjunction with state and county chairmen.

It is hoped that at the Fall (1969) meeting of presidents and presidents-elect of component societies of MSNJ and the Board of Trustees time will be allotted to include and elaborate on the subject of medicine and religion.

Approved (page 415)

Project Hope/Vietnam

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

The House of Delegates, at the 1968 Annual Meeting in Atlantic City, voted to approve the recommendation of the Board of Trustees "That Project Hope and Vietnam be established as a joint continuing program of The Medical Society of New Jersey, subject to any subsequent modification by the House of Delegates; and that a maximum of six fellowships be awarded annually on a 'first-come, first-served' basis, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S.S. HOPE, her sister-ship, or voluntary service in Vietnam."

In the course of the year the following two applications were received and authorized:

Project Hope Fellowship

Robert W. Tilney, Jr., M.D. (Morris County) $500 — tour of duty scheduled for 13 October to 15 November 1968.

Volunteer Physicians for Vietnam Fellowship

James R. Wiant, M.D. (Hunterdon County) $1,000 — tour of duty scheduled for 27 January to 27 March 1969.

Approved (page 413)

Retirement Plans for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

At the last annual meeting, the House of Delegates asked the Committee on Retirement Plan for Physicians to investigate the possibility of providing a Keogh Program for members of the small counties in New Jersey similar to the program established in Essex and Union Counties. Essex County has adopted a two-fold program which features the variable annuity concept instituted by the E. & W. Blanksteen Agency, Inc., and underwritten by The Prudential Insurance Company of America and also an alternate plan set up by the Morrisey Associates Agency of Newark, New Jersey. In Union County the variable annuity plan as set up by PRU was adopted as well as the PRO Plan for Keogh, which also includes a variable annuity concept. The PRO Plan is already available in seventeen counties in the State. As a result of this mandate, contact was made with E. & W. Blanksteen Agency who are now seeing if this can be effected. This agency assures us that they have obtained from Prudential an agreement to put a program into effect whereby the balance of the members throughout the state could participate in a trust setup under the aegis of The Medical Society of New Jersey.

The rest of the Committee has been kept informed relative to the situation, and it seems by personal contact with them that they feel the plan has merit and is worthy of consideration by the Society.

Mr. Blanksteen feels, however, that this plan should be set up under the aegis of MSNJ. Up to the present time the Board of Trustees has been unwilling to approve a trust agreement for the state on this basis.

Negotiations are still going on with Mr. Blanksteen to pursue the idea that it might be possible for several counties to combine and set up a trust agreement under their coordinated sponsorship.

There is no new development in the Keogh HR-10 law. We again urge the membership to take advantage of the government legislation allowing them under certain conditions to set up a retirement plan with a considerable amount of tax savings.

Many plans are available at present, either on a county, national, or specialty group basis. There are also many individual options available through banks, insurance companies, mutual funds, and other investment channels.

We also remind the membership that they do not have to wait for a specific state plan. They can start with any plan, and at some future date if they so elect they may transfer to a different plan without penalty.

Recommendation

That the Committee on Retirement Plan for Physicians be continued as a means of keeping the Society informed as to any changes in the retirement setup for physicians and also to effect any program which the Society may deem advisable.

Approved (page 414)

Movie On Head Injury

Now available is a 30-minute color film (16 millimeter) on practical pointers in the emergency treatment of head injury. This is not only for interns, nurses, and medical students, but will also be valuable to first-aid squads and ambulance and rescue teams. While it will cost you $160 to buy the film, you can rent it for only $7.50 a showing. Johns Hopkins has developed the film. For more details write to Milner Fenwick, 3800 Liberty Heights Avenue, Baltimore, Maryland 21215.

Traffic Safety

Irwin S. Smith, M.D., Chairman, Willingboro
(Reference Committee "D")

The Council on Legislation referred Senate Bill S-97 of 1968 to the Committee for study and recommendation. This bill would require every applicant for a motor vehicle driver's license upon first applying — and every six years thereafter — to submit to, and pass, a hearing and eye examination as shall be prescribed by the Director of Motor Vehicles.

We informed the Council on Legislation that in our opinion the bill should be disapproved because it is too broadly drawn and imposes unnecessarily on the citizens licensed to drive in New Jersey while placing a tremendous burden upon the Division of Motor Vehicles.

The Committee felt that rules and regulations in this area should be formulated only after an advisory panel, appointed by the Director of Motor Vehicles, studied and approved such rules. This advisory panel should consist of professional practitioners in the field of vision.

The foregoing sentence was amended to read:

This advisory panel should consist of professional practitioners in the respective fields.

Resolution 19 of the 1968 House was not adopted but it was referred first to the sponsor for better wording and clarification, and then to this Committee so that its content might be studied and discussed with the New Jersey Division of Motor Vehicles. The core concern of Resolution 19 was to relieve the physician of making any declaration as to the safety or competence of automobile drivers and to assign this determination to the motor vehicle authorities.

In the Committee we decided that the proper course of action would be to discuss with the New Jersey Division of Motor Vehicles the entire area of physical examinations for automobile operators and, in particular, the wording of the reporting forms to be completed by physicians. This effort will be one of our prime concerns in the forthcoming year.

We plan also to concern ourselves with the problem of the drinking driver and the legislative and enforcement procedures that are indicated.

Approved as amended **(page 415)**



Dr. Ashton B. Morrison accepting AMA-ERF check from President Kustrup for Rutgers Medical School.

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

After less than a year's stewardship of Medical-Surgical Plan, it gives me considerable pleasure to report that the year 1968 was notable for growth and progress on many fronts of the Plan's operations, while a relatively stable financial condition was maintained.

Membership registered an impressive gain of 187,973 persons, bringing the total enrollment to a record 3,096,772. The 3,000,000th member was enrolled half-way through the year, with appropriate observances marking this milestone.

Benefits paid on behalf of members also reached a new high. Claims incurred during 1968 amounted to over $58.5 million, an increase of $5.5 million over the preceding year. At year's end the reserves represented about 1.6 months of claims and operating expenses.

The number of Participating Physicians increased during the year, both in Basic programs and the Prevailing Fee Program.

A new method of billing patients was developed and recommended to Participating Physicians, which greatly simplifies the problem of establishing the patient's entitlement to service benefits. This method was described in the April issue of the Journal of The Medical Society of New Jersey.

Coverage of usual and customary charges under the Prevailing Fee program gained considerable impetus among National Account groups, and there is every indication that Prevailing Fee will become one of the larger Blue Shield programs of the future.

Extended benefits for many services in the doctor's office were incorporated in a Rider offered to Medicare beneficiaries enrolled in the "Blue Cross and Blue Shield 65" program.

The Plan campaigned vigorously, together with Blue Cross, for designation as carrier for the State's Medicaid Program. As of this writing, the Blue Plans are leading contenders for the role.

Along with other Blue Shield Plans, Medical-Surgical Plan undertook to make available a comprehensive scope of benefits from which National Accounts could fashion a well-rounded health care program.

The Plan's membership growth—greatest in over a decade—adequately answers a few prophets of doom who only recently foresaw the decline and possible dissolution of Blue Shield as the result of encroaching government programs and increasing competition in the market place from both commercial and non-profit plans. The most significant gains were in the categories of National Accounts—some 80,000 persons—and the addition of Rider J coverage by 225,000 members. At year's end over 1,300,000 persons held Rider J.

The moral here is plain, and the path for the future well-marked: (1) Large companies want a Blue Shield system flexible enough to provide tailor-made programs on a uniform basis, and (2) the entire market is seeking broader coverage, much of which probably will be on a Prevailing Fee basis.

In response to this demonstrated trend, Medical-Surgical Plan joined with other Blue Shield Plans in undertaking to make available a uniform Comprehensive Benefits program that could meet the various individual requirements of National Account groups. The benefits to be made available, beyond those already offered by the Plan, will be offered only to those National Accounts desiring additional coverage and willing to pay more for it.

In a related vein, gains were noted in subscribers covered for usual and customary fee payment under the Prevailing Fee Program. Such a program may be elected as the payment

mechanism for the national Comprehensive Benefits Program, and all Blue Shield Plans now must offer a usual and customary program as well as Comprehensive Benefits. Medical Surgical Plan, of course, has had such a program in operation since 1967. Now covered under Prevailing Fee are the Steel and Motors Industries, Uniroyal Corporation, Federal employees, dependents of servicemen and retirees of the uniformed services and their dependents (CHAMPUS) as well as others. Predictably additional large accounts will seek this type of coverage in increasing numbers, and we expect that by the end of 1969 about 300,000 persons will be covered under Prevailing Fee. The Sales Department is making continuous efforts to sell Prevailing Fee to new accounts, as well as to convert existing accounts from Basic to Prevailing Fee coverage. Because of the increased income of the average New Jersey worker, it is estimated that less than 40% of family subscribers now have incomes (husband and wife) under $7,500. It is certainly in the interest of the remainder of the enrolled population to be covered for usual and customary charges under Prevailing Fee. The present philosophy of the Plan is that the future of Blue Shield will be in the area of Prevailing Fee, which will afford better coverage to subscribers and usual and customary payment to physicians. It is not our intent to raise the current income levels of the Basic program, because we must continue to provide service benefits to people in this lower middle income level, who will continue to be strong advocates of the private practice of medicine, so long as such care is available at a premium they can afford to pay.

A significant boon to older citizens holding "Blue Cross and Blue Shield 65" coverage complementing Medicare was the development of a Rider covering many services in the doctor's office (the basic "65" program provides benefits only for in-hospital services.) Rider 65, at a quarterly premium of $2.34, offers coverage for surgery, radiology and physical therapy in the doctor's office, and pathology in the office or bioanalytical laboratory. Prior to introduction of the Rider, a "65" subscriber had to be a hospital inpatient or outpatient to have these services covered.

It is gratifying to note that on March 7, 1969, Governor Hughes filed without approval Senate Bill 363, and issued a comprehensive statement as to why he did not approve this Bill, which would have mandated the payment of Blue Shield benefits for eligible services rendered to subscribers and their dependents by licensed chiropractors. The Plan wishes to compliment Dr. John F. Kustrup, President of The Medical Society of New Jersey, and Dr. Jesse McCall, Chairman of the Society's Council on Legislation, together with the other Council members, for the cogent arguments they presented against the Bill: we were happy to participate with them in this action, which was definitely in the interest of the people of New Jersey, and in particular the Plan's three million members.

Working closely with our companion Blue Cross Plan, Hospital Service Plan of New Jersey, Medical-Surgical Plan actively and vigorously sought the role as carrier for the State's Medicaid program (Title XIX). It was completely in keeping with Blue Shield's traditional role that the leader in medical-surgical prepayment should offer its knowledge, experience and facilities to the worthy objective of returning the medically underprivileged to the mainstream of quality medical care.

The Plan's Board of Trustees was strengthened by the election in May, 1968, of Dr. Donald T. Akey, surgeon, and Dr. Henry J. Mineur, cardiologist, both outstanding practitioners in their fields, and Mr. James T. Crowley, an executive of Moore-McCormack Lines, Inc., a business leader with labor union experience. The top administration of the Plan was augmented by the election of Dr. Jerome C. Rothgesser, who had been Associate Medical Director, to the posts of Vice President-Medical Affairs and Medical Director.

Financially, as in other respects, 1968 was a good year for the Plan. While the amount of benefits provided, number of services paid and claim incidence among our enrolled population all reached new highs, and our operating staff consequently had to be expanded, we ended the year in the black, with a small contribution to reserves.

In closing, I wish to express my appreciation of the invaluable counsel and guidance I received from the Board of Trustees in assuming the challenging but rewarding post of President, as well as acknowledging the loyal and dedicated support of the Plan's staff. And last, but most important, my gratitude for the understanding cooperation of the Participating Physicians who make Blue Shield service benefits possible for the most deserving 40% of our enrollment within the lower middle income range, who can continue to enjoy excellent medical care and a satisfying doctor-patient relationship at a cost they can afford because of the Blue Shield coverage provided through the voluntary system.

Comparative Balance Sheet December 31, 1968

Assets	*1968*		*1967*
Cash on Hand and in Banks (Working Funds)	$ 1,062,444		$ 294,028
Investments	22,799,427		19,550,882
Accounts Receivable:			
Subscriptions	1,514,115		1,052,176
National Account Program	1,649,590		1,309,465
Federal Employee Program	875,465		700,766
Hospital Service Plan	486,184		—
Other	71,147		29,918
Accrued Interest and Dividends Receivable	306,703		210,322
Total Assets	$28,765,075		$23,147,557
Liabilities			
Claims Outstanding:			
Reported	$3,689,000	$2,751,000	
Unreported	7,858,000	7,356,000	
National Accounts	891,000	375,000	
	$12,438,000		$10,482,000
Unearned Subscriptions	3,379,692		2,946,981
Accounts Payable—			
Hospital Service Plan	—		1,949,947
Miscellaneous	1,063,720		1,085,988
Reserve For Group Contract Settlements	2,139,538		1,365,680
Deposits From Other Organizations	747,309		573,554
Total Liabilities	$19,768,259		$18,404,150
Reserves			
Securities Valuation	$ 692,000		$ 593,000
Special Contingent	100,000		100,000
Unassigned	8,204,816		4,050,407
Total Reserves	$ 8,996,816		$ 4,743,407
Total Liabilities and Reserves	$28,765,075		$23,147,557

Annual Statistics—1968

TABLE I

Distribution of All Services and Payments

Paid 1968	*Total Services*	*% All Services*	*Payment*	*Percent*	*Payment Per Service*
Surgical	524,846	40.9%	$27,636,730	50.4%	$52.66
Medical	513,631	40.0	16,315,180	29.8	31.76
Obstetrical	41,143	3.2	5,830,815	10.6	141.72
Consultations	59,541	4.6	1,185,899	2.2	19.92
Anesthesia	144,165	11.3	3,852,978	7.0	26.73
Total	1,283,326	100.0%	$54,821,602	100.0%	$42.72

TABLE II

Distribution of Rider Services and Payments

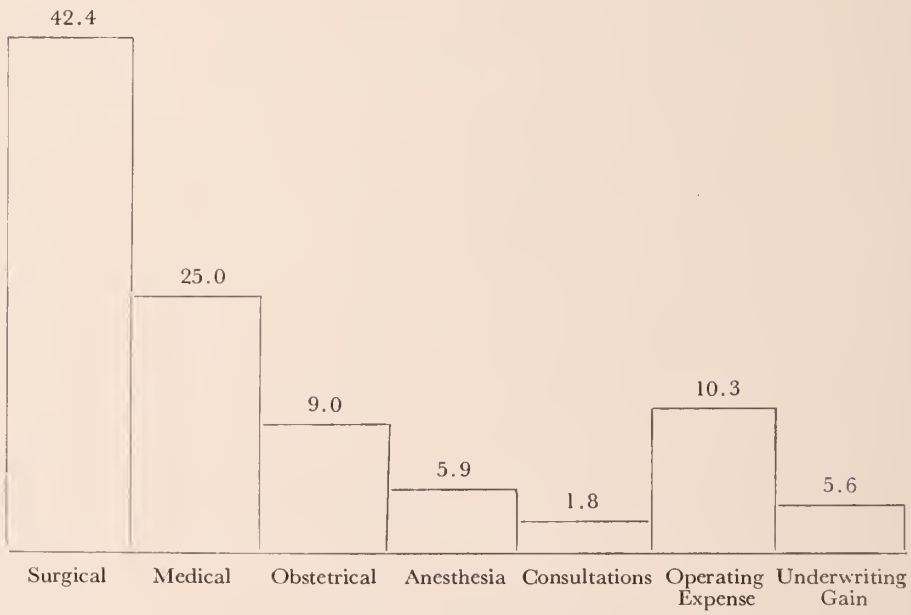
	Total Services	*% All Services*	*Payment Amount*	*Percent*	*Payment Per Service*
Surgical	52,201	15.8%	$1,065,355	17.1%	$20.41
Medical	5,266	1.6	301,383	4.8	57.23
Diagnostic X-Ray	129,373	39.3	2,825,624	45.3	21.84
X-Ray Therapy	944	0.3	149,494	2.4	158.36
Physical Therapy	10,489	3.2	283,696	4.5	27.05
Pathology	131,214	39.8	1,618,422	25.9	12.33
Total	329,487	100.0%	$6,243,974	100.0%	$18.95

Excludes Federal Claim Data.

TABLE III

Distribution of Earned Subscription Income

Earned Subscription Income	$69,591,590	100.0%
Incurred Claims	58,536,205	84.1
Operating Expense	7,148,371	10.3
Underwriting (Gain)	3,907,014	5.6



FEDERAL EMPLOYEE PROGRAM

Following is a statement of income and expense, along with utilization statistics of the 1968 experience of the Federal Employee Program.

Income	$2,795,325	100.00%
Claims incurred	2,591,990*	92.73
	$ 203,335	7.27
Operating Expense (Estimate)	174,000	6.22
Gain	$ 29,335	1.05%

Paid Basis

Average Exposure (Persons)	119,869
Services per 1,000 Persons Enrolled	348
Average Cost Per Service	$ 57.77
**Number of Services	41,715
Amount Paid	$2,409,990*

*NOTE: Despite their similarity, these figures represent different categories: Claims Incurred include claims for 1968 services that were not paid until after 1968; Amount Paid represents actual disbursements made in 1968, including those for services rendered prior to 1968.

**Due to a change of processing, number of services rather than cases are being recorded.

Claims Incurred

Year	Amount
1968	$58,536,000
1967	53,016,000
1963	40,991,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

Incidence Rate (Cases) Per 1,000 Persons Enrolled

Year	Incidence
1968	304
1967	275
1963	193
1960	166
1957	143
1954	126
1951	112
1948	96
1945	86
1942	40

Civilian Health and Medical Program of the Uniformed Services

Effective December 1, 1967, the Plan, with the approval of The Medical Society of New Jersey, was designated as contractor for the program, which on the same date adopted a usual and customary charges basis of payment, replacing the fixed fee schedule previously utilized.

Following is the claim experience for 1968:

CLAIMS

Period	*Received*	*Declined*	*Returned Incomplete*
Total Claims 1968	28,016	1,240	12,039

Paid		
Claims	*Amount*	*On Hand*
15,038	$1,186,207	324

City of Newark Medical Plan

Effective June 1, 1965, Medical-Surgical Plan of New Jersey assumed the administrative functions of the City of Newark Medical Plan on behalf of Medical Service Administration of New Jersey.

Approved services rendered from January 1, to December 31, 1968, as compared with former years, were:

RELIEF

Year	*Number of Cases*	*Value of Services*
1961	1484	$6,914
1962	1151	$5,329
1963	1149	$5,339
1964	1164	$5,736.50
1965	1128	$6,287.50
1966	682	$3,770
1967	831	$4,670
1968	868	$4,857.50

MEDICALLY INDIGENT

Year	*Number of Cases*	*Value of Service*
1961	1732	$8,197
1962	1252	$5,999
1963	1189	$5,587
1964	862	$4,420
1965	962	$5,585
1966	931	$5,395
1967	482	$2,707.50
1968	361	$2,137.50

Public Relations Program

Early 1938 saw the culmination of the Plan's 25th Anniversary celebration, which had represented a major public relations effort extending through most of the preceding year. The final presentation of 25-year Participating Physician plaques was made at a meeting of the Passaic County Medical Society, bringing to over 900 the number of pioneer physicians so recognized throughout the State's 21 counties. An illustrated report on the anniversary program was submitted to the Blue Shield Board of Trustees, other Blue Shield Plans and National Association of Blue Shield Plans. A photo of a montage of over 150 press clippings on the anniversary observances was published in The Blue Shield, NABSP newspaper.

A display depicting highlights of the anni-

versary program, with samples of the media used in publicizing it, was shown at the 1968 Blue Cross and Blue Shield National Advertising and Public Relations Conference in Los Angeles.

Favorable public attention was again directed to Medical-Surgical Plan in 1968 through a program celebrating the enrollment of the Plan's 3,000,000th member. The "milestone member" was honored at a luncheon attended by officials of his company, Blue Shield and Blue Cross, at which he was presented with an illuminated and engrossed scroll by Dr. Joseph P. Donnelly, Plan President. News releases and photos of the occasion were accorded good acceptance by the press, and inquiries were received from other Blue Shield Plans that were planning similar observances.

A major public relations endeavor, undertaken in cooperation with Hospital Service Plan Public Relations, was a program aimed at building a receptive climate among the various publics toward the Blue Plans as the logical carriers for the State's Medicaid Program, based on their long-established expertise in the health care prepayment field, their cost control mechanism and their nonprofit character. This was carried forth in the legislative field by the capable efforts of W. Jefferson Lyon, Hospital Service Plan Vice President-Public Relations and Dr. Donnelly.

The opportunity to exchange ideas and techniques while working closely with public relations executives of other leading Plans was afforded the Public Relations Officer through his election as secretary, and subsequently vice chairman, of the Blue Cross and Blue Shield Mid-Atlantic Public Relations Conference.

In conjunction with Hospital Service Plan Marketing and Public Relations, the Public Relations Officer participated in behalf of Medical-Surgical Plan, in the joint sales and institutional advertising campaigns, and administered Medical-Surgical Plan's individual institutional advertising program. These activities included preparation of advertisements for the leading dailies and weeklies of the state, specialty publications, billboards, bus cards, and radio stations.

A helpful innovation during the year was the establishment of a well-staffed Editorial Services Department by Hospital Service Plan, which assumed for both Plans the functions of physical preparation of informational and educational materials, publications and other printed matter. Close liaison exists between the Department and the Medical-Surgical Plan Public Relations Officer, who maintains editorial authority over all Blue Shield material produced by the Department.

In other areas, the Public Relations Office assisted in the preparation of many types of communications to physicians, subscribers, medical societies, other Blue Shield Plans, NABSP, the Department of Banking and Insurance and other governmental officials. Such assistance was provided to a number of Plan executives and departments including the President, Executive Vice President, Vice President for Medical Affairs, Director of Operations, Physician Relations Section and Utilization Review Section.

Physician Relations Program

The Physician Relations Section accomplished its 1968 objective of maintaining liaison and cooperation between the Plan and thousands of doctors throughout the state.

It is noteworthy that at year's end the number of Participating Doctors under the Basic Program stood at a new high of 7,167, a gain over 1967 of 141, and the upward trend continued in 1969. Represented in the total are 5,900 Doctors of Medicine, 565 Doctors of Osteopathy, 336 Doctors of Podiatry, 107 Registered Bioanalytical Laboratories and 259 Doctors of Dental Surgery. These participants make a vital contribution to the citizens of New Jersey. During 1968 only eight resignations of Participating Doctors were recorded, the lowest number in many years.

Although two experienced Field Representatives were lost through promotion within the Plan, four new Field Representatives were

hired and trained. Three of these have completed their training, and substantial increase in both the scope of activities and the number of contacts in the Field Program is assured for 1969. It was necessary to curtail the 1968 Field Program in order to process thousands of Participating Agreements under the Prevailing Fee Program and handle numerous revisions of individual Prevailing Fee Schedules for Participating Doctors. Approximately 5,400 doctors were enrolled as participants for Prevailing Fee; such participation is separate and apart from participation under the Basic Program.

Despite greatly increased office activities a number of field contacts were made, including hospital staff meetings, physician lounges of hospitals, visits to individual doctors' offices, manning exhibits at several conventions and other meetings including those of specialty societies and medical assistants. The Physicians' Inquiry Unit was strengthened by the addition of two telephone clerks, bringing the total to eight. Every opportunity is taken to remind doctors and their office assistants to call this unit,— (201) 662-2201 — for assistance on any problems dealing with Plan payments, policies or procedures. Doctors are also urged to obtain the name of the clerk handling their inquiry, so that the Plan may exercise controls that will assure the best possible service.

With an authorized staff of six Field Representatives — five positions being filled at year's end — and an augmented Physicians' Inquiry Unit, we are confident that a comprehensive field Program and good telephone service will result in 1969.

Enrollment Report

The total membership of Medical-Surgical Plan in 1968 increased 6.5 per cent. This represents a net gain of 187,973 persons and 88,359 contracts. Total membership at year-end thus stood at 3,096,772 persons. Nationwide statistics show the Plan has strengthened its fifth rank position among all Blue Shield Plans. Gains in all major lines of business, i.e. Group, Left-Group, Non-Group and Complementary coverage were produced in 1968. Group business accounts for more than 81% of total membership. The 2,523,387 persons so covered can be divided into four major classes: Basic coverage both with and without riders, Government lines, National Account coverages, and coverage complementary to Medicare. The Basic certificate is held by 67% of Group members — a drop of four percent from the 1967 level. The governmental coverages now account for 12% of total Group, reflecting a thirty-three thousand member increase. National Accounts have shown the largest growth — to a 17% share — via a net gain of 78,688 members. Complementary coverage lost 2,095 net members to hold a 4% share of the Group line. The trend to more inclusive and tailored benefits is still very much evident. It is indicated by the 180,000 persons who added Rider J to their certificate last year; in all Rider J gained 225,000 members.

The Direct Payment Membership areas were also advanced in 1968. Membership transferred from former Group coverage was up by 14,768 persons. Newly enrolled membership gained 30,570 persons. A net addition of 11,382 subscribers was recorded in the BC-BS "65" program. Enrollment for the three subcategories stood at: Left-Group, 212,308 members; Non-Group, 234,667; and BC-BS "65", 126,356. This represents an overall increase of 11.0% in the Direct Payment line over the year-end 1967 level.

In reviewing areas of growth for 1968, special mention must be made of enrollment under the Prevailing Fee Program for National Accounts. At year-end, over 87,000 contracts representing an estimated 265,000 members were enrolled under this program. Current reports from the sales staff indicates a growing market demand for this program.

Enrollment Growth

Year	Enrollment
1968	3,096,772
1967	2,908,799
1963	2,450,755
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

COMPARATIVE SUMMARY OF OPERATIONS

	1968			*1967*	
Subscriptions Earned*	$69,591,590	100.0%		$60,878,649	100.0%
Less:					
Claims Incurred**	$58,536,205	84.1	$53,016,326		87.1
Operating Expenses***	7,148,371	10.3	5,618,439		9.2
	65,684,576	94.4%		58,634,765	96.3%
Gain from Underwriting Operations	$ 3,907,014	5.6%		$ 2,243,884	3.7%
Income on Investments	1,052,259			695,095	
Operating Gain for the Year	$ 4,959,273			$ 2,938,979	

*The gain of $8,712,941 in subscriptions earned reflects gains in enrollment, which increased by 187,973 during the year and the 12% rate increase effective 5/1/67.

**The rise of $5,519,879 in claims incurred is attributable to increased exposure from larger enrollment, and to increased incidence, which rose from 275 per 1,000 persons to 304.

***The increase of $1,529,932 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $1,238,770 and an increase of $291,162 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense increased by one and one tenth percent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

		1968		*1967*
Reserves at January 1		$4,743,407		$ 861,587
Operating Gain or (Loss) for the Year		4,959,273		2,938,779
		$9,702,680		$3,800,366
Plus: Reserve Adjustments				
Non-Admitted Assets	($77,808)		($164,393)	
Adj. of Prior Year's Income	360,000			
Unrealized Capital Gains	150,852		209,464	
Claim Reserve	(690,000)		1,450,000	
Distribution of Prior Year's Income	(179,000)		(354,513)	
Group Contract Settlement	(269,908)	(705,864)	(197,717)	942,841
		$8,996,816		$4,743,407

The increase of $4,253,409 in reserves for the protection of Plan Subscribers is due to a net operating gain of $4,959,273 and reserve adjustments totaling ($705,864).

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

		Atlantic	Bergen	Burlington	Camden	Cape May	Cumberland	Essex	Gloucester	Hudson	Hunterdon	Mercer	Middlesex	Monmouth	Morris	Ocean	Passaic	Salem	Somerset	Sussex	Union	Warren	Out of State	Total
	Total Eligible Physicians	245	1165	240	658	69	127	1702	153	724	65	516	524	518	469	167	665	57	187	62	827	48	273	9461
PARTICIPATING	Total	222	660	211	569	63	120	1339	130	597	58	414	385	360	373	110	468	53	141	57	547	47	243	7167
	M. D.	180	524	155	356	44	99	1185	80	523	57	367	335	307	306	89	389	42	128	43	437	44	210	5900
	D. O.	15	59	33	150	9	6	43	30	12		15	16	17	28	12	29	6	5	6	46	1	27	565
	D. S. C.	13	31	10	31	4	6	64	8	35		16	14	14	8	5	29	2	3	1	38		4	336
	Lab.	7	15	2	7	2	3	17	3	5		5	9	3	9	1	6	1	1	1	7	2	1	107
	D. D. S.	7	31	11	25	4	6	30	9	22	1	11	11	19	22	3	15	2	4	6	19		1	259
NON-PARTICIPATING	Total	23	505	29	89	6	7	363	23	127	7	102	139	158	96	57	197	4	46	5	280	1	30	2294
	M. D.	20	450	24	79	3	4	310	20	112	6	89	115	135	75	49	169	3	38	5	248	1	30	1985
	D. O.	1	15	4	5	3	1	10	2	1		4	1	5	2	2	2	1	1		5			65
	D. S. C.		3		2			3		2			2	1	2		2		1		1			19
	Lab.		1					4		1			2			1	1		1		1			12
	D. D. S.	2	36	1	3		2	36	1	11	1	9	19	17	17	5	23		5		25			213
	% P. P. as of 12-31-68	90.6	56.6	87.9	86.4	91.3	94.4	78.6	34.9	82.4	89 2	80.2	73.4	69.5	79 5	65.8	70.3	92.9	75.4	91.9	66.1	97.7	89.0	75.7
	% P. P. as of 12-31-67	90.5	56.7	87.6	86.9	90.1	94.4	79.4	86.1	81.4	90.7	79.8	75.3	70.4	79.4	67.9	71.2	92.5	76.6	91.3	66.8	96.0	88.6	76.2

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY SPECIALITY

		Anes.	Derm. Syph.	Int. Med.	Neur. Surg.	Obst. Gyn.	Ophth.	Orth. Surg.	Otol.	Path.	Ped.	Phys. Med.	Plast. Surg.	Analy. Labs.	Proct.	Psy. & Neuro.	Radiology	Surg.	Thor. Surg.	Urol.	Chiropody	General	Dentists	Total
	Total Eligible Physicians	385	149	1258	54	684	283	268	186	158	481	20	33	119	39	377	231	834	32	187	354	2855	474	9461
PARTICIPATING	Total	171	112	953	26	363	181	164	118	133	428	16	9	107	24	261	177	625	22	96	336	2585	260	7167
	M. D.	159	112	930	26	355	180	158	114	129	424	15	8		17	259	170	605	22	94		2122	1	5900
	D. O.	12		23		8	1	6	4	4	4	1	1		7	2	7	20		2		463		565
	D. S. C.																				336			336
	Lab.													107										107
	D. D. S.																						259	259
NON-PARTICIPATING	Total	214	37	305	28	321	102	103	68	25	53	4	24	12	15	116	54	209	10	91	19	270	214	2294
	M. D.	208	37	304	28	319	102	103	67	24	53	4	24		15	116	54	207	10	91		218	1	1985
	D. O.	6		1		2			1	1								2				52		65
	D. S. C.																				19			19
	Lab.													12										12
	D. D. S.																						213	213
	% P. P. as of 12-31-68	44.4	75.1	75.7	48.1	53.0	63.9	61.2	63.4	84.1	88.9	80.0	27.2	89.9	61.5	69.2	76.6	74.9	68.7	51.3	94.9	90.5	54.8	75.7
	% P. P. as of 12-31-67	47.9	74.4	75.8	39.6	53.0	62.5	61.2	63.1	82.5	89.4	78.9	30.0	90.0	62.1	72.3	71.6	74.2	62.9	53.1	94.3	90.3	54.9	76.2

1968 BOARD OF TRUSTEES

Chairman of the Board

Thomas J. White, M.D., (1971)

First Vice President

Jerome G. Kaufman, M.D. (1970)

Second Vice President

Rudolph C. Schretzmann, M.D. (1971)

Donald T. Akey, M.D. (1969)
Edwin H. Albano, M.D. (1971)
Robert G. Boyd (1969)
Joseph A. Cox, M.D. (1969)
James F. Crowley (1971)
Charles L. Cunniff, M.D. (1969)
Andrew P. Dedick, Jr., M.D. (1969)
†Joseph P. Donnelly, M.D. (1970)
Edgar P. Eaton, Jr. (1970)
Joseph I. Echikson, M.D. (1970)
Lloyd M. Felmly (1971)
Edwin T. Ferren, D.O. (1970)
Mortimer J. Fox, Jr. (1970)
Joseph P. Keating, M.D. (1970)
John F. Kustrup, M.D. (1969)
Elton W. Lance, M.D. (1970)
Samuel J. Lloyd, M.D. (1971)
Theron L. Marsh (1971)
Jesse McCall, M.D. (1971)
Earl R. Mellen (1969)
Henry J. Mineur, M.D. (1970)
James R. Pepper (1969)
Warren H. Simmons (1969)
Sidney I. Simon, Ph.D. (1969)
Charles O. Tyler, M.D. (1971)
Robert E. Verdon, M.D. (1969)

TRUSTEES EMERITUS

	Appointed	*Term as Board Member*
Edward W. Sprague, M.D.	1966	1942–1966
John S. Thompson	1966	1942–1965

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
William F. Costello, M.D.	1958	1948–1958
William E. Dodd, M.D.	1952	1944–1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.
1945–1945
*Charles W. Barkhorn, M.D.
1952–1965
Irving P. Borsher, M.D.
1950–1965
*F. Clyde Bowers, M.D.
1961–1963
*Theophilus H. Boysen, M.D.
1944–1945
Lewis W. Brown, M.D.
1949–1954
*William J. Carrington, M.D.
1942–1943
*Harry N. Comando, M.D.
1942–1958
*Samuel A. Cosgrove, M.D.
1944–1953
*William K. Harryman, M.D.
1944–1945
Sigurd W. Johnsen, M.D.
1942–1948
*Augustus S. Knight, M.D.
1942–1948
*Thomas K. Lewis, M.D.
1942–1949
*Arthur W. Lunn
1951–1962
Paul Mecray, Jr., M.D.
1953–1961
Duane E. Minard, Jr.
1957–1965
Glennis S. Rickert, M.D.
1959–1963
*Royal A. Schaaf, M.D.
1942–1964
*Norman M. Scott, M.D.
1942–1950
Reuben L. Sharp, M.D.
1950–1952
James J. Spencer, M.D.
1957–1961
Gustave E. Wiedenmayer
1961–1966
*Carl K. Withers
1952–1961
David L. Yunich
1962–1963

†Resigned April 23, 1968
*Deceased

Approved (page 413)

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1969 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Bergen County

Canio Bibbo, River Edge; Age 64
George W. Caldwell, Tenafly; Age 70
Luther A. Markley, Westwood; Age 70
Norman V. Myers, Red Bank; Age 61

Burlington County

Joseph M. Kuder, Mount Holly; Age 77
Milton M. Schisler, Miami, Fla. (formerly Florence); Age 70
S. Emlen Stokes, Moorestown; Age 75
David H. Bartine Ulmer, Moorestown; Age 84

Essex County

Jeremiah L. Buckley, Lavallette; Age 69
S. William Kalb, Hillside; Age 71
Herbert L. Mahood, Hightstown; Age 71
William J. Marquis, East Orange; Age 73
Grace T. Newman, Jamesburg; Age 68
Charles F. Turner, Sherman Oaks, Calif. (formerly Montclair); Age 72

Gloucester County

Paul McD. Pegau, Woodbury; Age 69

Hudson County

Edward Alpert, Hollywood, Fla. (formerly Jersey City); Age 70
Henry C. Fattel, North Bergen; Age 65
John L. Howeth, Stockton; Age 61

Middlesex County

Jack M. Kluft, Perth Amboy; Age 56

Passaic County

Alphonse P. Del Mauro, East Paterson; Age 62
Frank F. Jani, Fort Lee; Age 65
Irving Okin, Delray Beach, Fla. (formerly Passaic); Age 70
H. Eugene Reading, Pompano Beach, Fla. (formerly Paterson); Age 74

Approved (page 426)

Supplemental Report

The following additional nominations for election to emeritus membership have been received:

Union County

Victor duBusc, Elizabeth; Age 76
Malcolm S. Edgar, Summit; Age 76
John L. Sly, Summit; Age 77

Approved (page 426)

RESOLUTIONS

#1

Assimilation of Osteopaths

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the American Medical Association House of Delegates in December 1968 adopted a report to provide avenues whereby fully licensed osteopaths may be assimilated into the mainstream of medicine, and

Whereas, this was done to assure the provision of the best possible health care to the American people and make available to osteopathic students and graduates, education of the same high standards as prevail in undergraduate, graduate, and continuing medical education programs, and

Whereas, the House of Delegates instructed the AMA Council on Constitution and By-Laws to prepare "Appropriate By-Laws amendments so that qualified Doctors of Osteopathy may be admitted to full active membership" in the American Medical Association, and

Whereas, the AMA House of Delegates suggested that "each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association," and

Whereas, the AMA House of Delegates suggested that state and county societies and other affected organizations "May proceed to make such constitution and bylaw changes as are necessary to implement the foregoing, now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey instruct the Committee on Revision of Constitution and Bylaws to prepare suitable amendments for their presentation of next year's annual convention to permit fully licensed doctors of osteopathy to become members.

Not adopted. The Reference Committee recommended that a special committee be established by the Board of Trustees to study this matter and report to the 1970 House of Delegates. (page 410)



Scientific Section in Session.

#2

Assimilation of Osteopaths

From the Hudson County Medical Society

(Reference Committee "A")

Whereas, the December 1968 House of Delegates of the American Medical Association adopted a report suggesting means whereby fully licensed osteopathic physicians may be assimilated into the mainstream of medicine; and

Whereas, this was done to make available to osteopathic students and graduates education of the same high standards as prevail in undergraduate, graduate, and continuing medical educational programs, which will ultimately benefit the American public; and

Whereas, the House of Delegates instructed the AMA Council on Constitution and Bylaws to prepare "Appropriate Bylaws amendments so that qualified Doctors of Osteopathy may be admitted to full active membership in the American Medical Asssociation," and

Whereas, many accredited hospitals have interns, residents and staff members who are osteopathic trained; and

Whereas, fully licensed Osteopathic physicians are duly licensed to practice medicine and surgery in the State of New Jersey; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey direct that the Society take whatever steps are necessary to permit fully licensed Doctors of Osteopathy to become members of The Medical Society of New Jersey.

Not adopted. The Reference Committee recommended that a special committee be established by the Board of Trustees to study this matter and report to the 1970 House of Delegates. (page 410)

#3

Classification of Membership

From the Hudson County Medical Society

(Reference Committee "A")

Whereas, the House of Delegates of the American Medical Association, at the Clinical Meeting in Miami Beach in December 1968, adopted Report J of the Board of Trustees, which declared: ". . . the Board believes that State Medical Associations should be urged to establish uniform classifications, based on the AMA membership categories and urge their county medical societies to do likewise"; and

Whereas, such a change in the classification of members would permit other than licensed doctors of medicine to hold membership in The Medical Society of New Jersey, even lay persons; and

Whereas, the present classification of members of The Medical Society of New Jersey is both orderly and satisfactory; now therefore be it

RESOLVED, that The Medical Society of New Jersey make no change in its present categories of membership.

STATEMENT

According to the present Constitution and Bylaws of the American Medical Association, there are two types of membership:

ACTIVE MEMBERS
SPECIAL MEMBERS

1. *ACTIVE MEMBERS:* Shall be *Regular* or *Service*

A. *Regular* Members — Regular Members shall be limited to physicians who are members of their state association and eligible to both vote and hold office in their state association. It includes dues-paying and dues-exempt classifications. Active members may be excused from the payment of AMA dues by their state association for the following reasons: financial hardship, illness, intern and resident training, retired from active practice, temporary service in the armed forces, or over 70 years of age. Regular members excused from the payment of dues shall not be entitled to receive any publication of the AMA except by subscription.

B. *Service* Members — This group includes all regular commissioned medical officers and commissioned medical officers of the reserve components on extended Active Duty (more than 2 years) with the U.S. Air Force, U.S. Army, U.S. Navy, U.S. Public Health Service; and permanent medical officers of the Veterans Administration; and those physicians who have been retired in accordance with Federal Law and do not engage in any gainful employment. Service members shall have the same rights and privileges as regular members but shall not be required to pay dues and shall not be entitled to receive any publication of the AMA except by subscription.

2. *SPECIAL MEMBERS:* Special Members are *Associate, Affiliate,* and *Honorary*

A. *Associate* Members — Associate Membership shall be limited to:

1. Those physician members of state associations who are ineligible for regular membership in the American Medical Association. They are to be certified for enrollment by the secretary of their state medical association.

2. Members of the armed forces on temporary duty (2 years or less). They are to be certified for enrollment by the Surgeon General of their respective service.

Associate Members may attend meetings of the scientific assembly, but may not vote or hold office in the American Medical Association. They shall not be required to pay dues and shall not be entitled to receive any publication of the AMA except by subscription.

B. *Affiliate* Members — Persons who belong to one of the following classes may become Affiliate Members, upon nominaton by the Judicial Council and election by the AMA House of Delegates at the annual convention:

1. Physicians who are members of National Medical Societies of foreign countries.

2. American physicians located in foreign countries or possessions of the U.S. and engaged in medical missionary, educational or philanthropic labors.

3. Dentists who hold the degree of D.D.S. or D.M.D. and who are members of the American Dental Association and their state and local dental societies.

4. Pharmacists who are active members of the American Pharmaceutical Association.

5. Teachers of medicine or of the sciences allied to medicine who are citizens of the U.S., and are not eligible to membership through state associations.

6. Scientists in sciences allied to medicine and others who have attained distinction in their fields of endeavor, who are not otherwise eligible to membership through state associations.

Affiliate members may attend meetings of the scientific assembly, but may not vote or hold office in the AMA. They shall not be required to pay dues and shall not be entitled to any publication of the AMA except by subscription.

C. *Honorary* Members—Physicians of foreign countries who have risen to pre-eminence in the profession of medicine and who attend an AMA Convention may be elected at that convention to Honorary Membership by the House of Delegates on nomination of the Board of Trustees. Honorary members may attend meetings of the scientific assembly, but may not vote or hold office in the AMA. They shall not be required to pay dues and shall not be entitled to receive any publication of the AMA except by subscription.

Resolution to make no change in categories of MSNJ membership adopted (page 410)

Public Post Mortems

Is it ethically proper to publish studies concerning the health or illness of public figures after their death?

The AMA Judicial Council states that one need not condemn those who, after the death of public figures, discuss their prior medical conditions. However, respect for the dignity of man, respect for the deceased, and respect for the medical profession strongly suggest that only some clear and meaningful benefit would justify such discussion.

#4

Relative Value Index

From the Board of Trustees

(Reference Committee "A")

Whereas, in 1962 the House of Delegates tabled consideration of a Relative Value Index for The Medical Society of New Jersey; and

Whereas, since that time — in consequence of the establishment of various governmental programs and the adoption by organized medicine of the concept of payment for professional services on the basis of usual and customary fees — the determination of satisfactory levels of compensation has become increasingly complex and important; and

Whereas, the existence of an official Relative Value Index for members of MSNJ would greatly simplify the process of accurately determining usual and customary fees; and

Whereas, such improvement of that process would facilitate favorable negotiations with governmental or other agencies; now therefore be it

RESOLVED, that this, the 1969 House of Delegates, lift from the table consideration of a Relative Value Index and direct the Board of Trustees to have prepared a revised and updated Relative Value Index to be presented to the House of Delegates for action.

Foregoing paragraph amended to read:

Resolved, that this, the 1969 House of Delegates, lift from the table consideration of a Relative Value Index and direct the Board of Trustees to have prepared by the Council on Medical Services a revised and updated Relative Value Index to be presented to the House of Delegates for action at its next meeting.

Adopted as amended by the Reference Committee (page 410)

#5

Discontinuance of AID Certification

From the Middlesex County Medical Society

(Reference Committee "C")

Whereas, hospital utilization committees are presently certifying the necessity for patient stay; and

Whereas, many utilization committees routinely use AID figures in calculating these needs in a convenient way; and

Whereas, AID certification is duplicating, in an expensive and less effective way, the work of utilization committees; now therefore be it

RESOLVED, that utilization committees be encouraged to use up-to-date AID figures in their work; and be it further

RESOLVED, that AID certification be stopped, to avoid duplicating utilization committee work and wasting money.

Not adopted. The Reference Committee feels that this procedure has greatly assisted utilization committees in determining and in assaying the average patient day. (page 414)

#6

Amend Abortion Laws

From the Essex County Medical Society

(Reference Committee "E")

Whereas, there are indications that the State of New Jersey will, in the future, modify and liberalize the current abortion law; and

Whereas, The Medical Society of New Jersey already has an established policy on such revision which is similar to the policy adopted by the American Medical Association; and

Whereas, in the recently enacted Maryland Law on Abortion two paragraphs were adopted which could be of vital importance to physicians and hospitals; now therefore be it

RESOLVED, that The Medical Society of New Jersey add to its official position that the following two paragraphs from the Maryland Law should be a part of any revised or liberalized New Jersey abortion law:

(a) No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or any other recriminatory action against him.

(b) No hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit such procedures shall not be grounds for civil liability to any person, hospital, or institution nor a basis for any disciplinary or other recriminatory action against it by the state or any person.

and, be it further

RESOLVED, that The Medical Society of New Jersey present this wording to all responsible parties studying the revision of New Jersey abortion laws and at all public hearings; and be it further

RESOLVED, that should a liberalized abortion law be adopted in New Jersey which does not contain the above provisions, that The Medical Society of New Jersey initiate legislation to incorporate them in the law.

Adopted (page 416)

#7

Chiropractic

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, it is the duty of a physician to protect, guard, and maintain the health of all he serves, and

Whereas, the practice of Chiropractic has been labelled as an unscientific cult by all who have objectively evaluated its principles, and

Whereas, the United States Department of HEW has excluded Chiropractic from Medicare because of its lack of scientific basis, and

Whereas, the National Council of Senior Citizens oppose Chiropractic, and

Whereas, the United States Supreme Court holds that a state has the right to refuse licensing to chiropractors unless they meet the standards of doctors of medicine, and

Whereas, in recent action, the State of New Jersey has raised doubt as to the legitimacy of Chiropractic; now therefore be it

RESOLVED, that The Medical Society of New Jersey is adamantly opposed to the practice and licensing of Chiropractic; and be it further

RESOLVED that The Medical Society of New Jersey aggressively petition the Governor and Legislature of the State of New Jersey to ban the practice of Chiropractic in this state; and be it further

RESOLVED, that this Resolution be implemented by all means available to The Medical Society of New Jersey until such time as its intent is accomplished.

Foregoing resolution amended by deletion of the first six paragraphs and changing the language of the second "Resolved" — amended resolution reads:

RESOLVED, that The Medical Society of New Jersey is adamantly opposed to the practice and licensing of Chiropractic; and be it further

RESOLVED, that The Medical Society of New Jersey aggressively petition the Governor and Legislature of the State of New Jersey to eliminate the future licensing of Chiropractic in this state; and be it further

RESOLVED, that this resolution be implemented by all means available to The Medical Society of New Jersey until such time as its intent is accomplished.

Adopted as amended by the House **(page 419)**

#8

Elimination of Fee Setting by the State In Workmen's Compensation Cases

From the Middlesex County Medical Society

(Reference Committee "E")

Whereas, fees in Workmen's Compensation Cases involving employees of the State of New Jersey are, by law, to be reasonable and based on the "usual fees and charges" of the community; and

Whereas, "usual fees and charges" are applied statewide by "Medicare," certain Blue Shield contracts and other insurance carriers; and

Whereas, the employees of the State of New Jersey are entitled to have the widest possible choice of physician, at no cost to the employee; now therefore be it

RESOLVED, that the cut-rate fee schedule of the State of New Jersey is unacceptable, being contrary to the best interests of both the employee and the physician, and be it further

RESOLVED, that the action of the Board of Trustees of The Medical Society of New Jersey, in condoning such activity of the State of New Jersey, is equally unacceptable; and be it further

RESOLVED, that The Medical Society of New Jersey demand that the State of New Jersey modernize its policy in this matter, so that all citizens of this sovereign state may be treated with impartial fairness and that all employees of this state, regardless of income level, will receive the best medical treatment possible.

Not adopted. A statement authorized by the Board of Trustees and published in The Journal (Vol. 66, #1, January 1969) makes it clear that the course of action indicated in this resolution would be detrimental to the patients concerned and to the physician who at present treats such patients. (page 419)

#9

Legislative Approach to Unjustifiable Professional Liability Suits

From the Essex County Medical Society

(Reference Committee "E")

Whereas, there has been a marked increase in the number of unjustifiable professional liability suits; and

Whereas, a recent poll indicated that many physicians are undergoing a change in attitude toward patient care because of this; and

Whereas, to achieve the best in patient care it is important that we attempt to create a more favorable legislative milieu for the practice of medicine; and

Whereas, other state medical societies inform us that they have placed specific bills to improve this situation before their legislatures and have had success in passing some of them; now therefore be it

RESOLVED, that The Medical Society of New Jersey give priority to the formation of a special committee to draft and attempt to implement legislation in separate bills on the following:

(1) Extend concept of privileged communication to the proceedings, and/or records of medical review committees of local medical societies and staff committees in hospitals.

(2) There shall be no monetary liability on part of and no cause for action for damages shall arise against any member of duly appointed committee of state or local professional society, or duly appointed member of a committee of a medical staff of a licensed hospital, provided that they are operating pursuant to written and duly adopted bylaws.

(3) Require the court upon motion of either party to proceed to a separate trial of the defense of the Statute of Limitations before any other issue if the case is tried, if in an action against a physician or surgeon, the answer pleads that the action is barred by the Statute of Limitations.

(4) Require that jury be instructed that plaintiff has burden of proving defendant's negligence, by a preponderance of evidence, and

that injury alone does not raise either a presumption or inference of negligence; and, be it further

RESOLVED, that this Special Committee of The Medical Society of New Jersey request to meet with committees of the State Legislature studying the separate bills introduced on these matters and be prepared to meet at the convenience of the legislators to fully explain their import.

Not adopted. It was felt that the objectives of this resolution may best to obained by referring the matter to the Conference Committee with the Bench and Bar. (page 419)



Inaugural Address, Dr. Nicholas A. Bertha.

#10

Limitation of Use of Eye Medication for Diagnostic Purposes

From S. Jerome Greenfield, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, the State Attorney General's Office has permitted optometrists to use eye medication for diagnostic purposes, and

Whereas, it is felt that the administration of any medication is not without hazard in the form of unwanted side effects and therefore should be properly the province only of licensed physicians, and

Whereas, some of these side effects—such as allergic conjunctivitis, glaucoma, iritis, retinal detachment, febrile reactions and skin rash—are recognizable and able to be treated by physicians rather than laity, now therefore be it

RESOLVED, that immediate legal steps be taken to rescind the effect of the recent Attorney General's ruling.

Not adopted, in view of the action taken by the Board of Trustees on 20 April, 1969 (page 419)

#11

Negligence Actions

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, claims against physicians for alleged negligent practice have increased to a degree where legal considerations adversely influence the course of patient care, and

Whereas, the cost of insurance against such claims is rising to an intolerable level and many carriers refuse to accept physicians for negligence insurance coverage, and

Whereas, many such claims are unjustified and some are settled in order to avoid the costs of defense, and

Whereas, The American Bar Association has denounced the practice of initiating negligence actions on a contingency fee basis except in cases of hardship, and

Whereas, juries are generally unqualified by experience and scientific training to evaluate the intricacies of medical problems, making it impossible to obtain a hearing before "one's peers"; now therefore be it

RESOLVED, that The Medical Society of New Jersey shall take appropriate steps leading to legislation which will halt this erosion of medical practice and further the cause of justice through the following:

(a) Prohibition of "contingency fees" except in cases of proven hardship.

(b) Provide for arbitration of malpractice claims by an impartial board of medical and legal experts.

(c) Stipulation of limits upon amounts payable to plaintiffs in settlement of medical negligence claims.

Not adopted. It was felt that the aims expressed in this resolution would best be served by referring this matter to the Conference Committee with the Bench and Bar. **(page 420)**

#12

Provision of Comprehensive Health Care

From the Essex County Medical Society

(Reference Committee "E")

Whereas, it is recognized that in some areas comprehensive health care is not available to all; and

Whereas, neighborhood health centers are being proposed through government-assisted programs under O.E.O., H.E.W., and Heart, Cancer and Stroke projects, and

Whereas, applications for such neighborhood health centers are open to any and all, without adequate coordinated planning; and

Whereas, the Essex County Medical Society believes that physicians and other health professionals must work together with consumer groups in seeing that the best health care is

provided with dignity in disadvantaged areas; now therefore be it

RESOLVED, that The Medical Society of New Jersey support the development of coordinated comprehensive health care centers in disadvantaged areas based on the following principles:

(1) That component county medical societies be represented at both the planning and administrative levels by two or more members recommended by their society; and

(2) That 24 hour patient service be available, seven days a week; and

(3) That free choice of center physicians obtain, with referral to family physician where indicated or upon request of patient; and

(4) That emphasis be placed on supplementing rather than supplanting current local health facilities.

Adopted (page 420)

#13

Revision of Medical Practice Act

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the Medical Practice Act is in need of major revision to clearly organize the many accrued amendments, deletions, and annotations and to modernize its scope and provisions and

Whereas, it is the responsibility of The Medical Society of New Jersey to encourage the framing of a new Act and to accept the duty of seeing that its provisions are consonant with the health needs and welfare of the people of our State, and

Whereas, the existent Act has been studied in detail by many of our component medical societies and recommendations have been submitted to The Medical Society of New Jersey's Special Committee to Review Statutes Related to the Practice of Medicine and Surgery in New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey, through the Special Committee to Review Statutes Related to the Practice of Medicine and Surgery in New Jersey, the Legislative Analyst, the Council on Legislation, and whatsoever other pertinent avenue, do everything in its power to encourage the framing and passing into law of a new Medical Practice Act consonant with the principles of the best in modern health care for the people of our state and providing adequate and effective means for enforcing its provisions.

Foreging "Resolved" amended to read:

Resolved, that The Medical Society of New Jersey, through the Special Committee to Review Statutes Related to the Practice of Medicine and Surgery in New Jersey, the Legislative Analyst, the Council on Legislation, and whatsoever other pertinent avenue, do everything in its power to encourage the framing and passing into law of needed revisions to the Medical Practice Act consonant with the principles of the best in modern health care for the people of our state and providing adequate and effective means for enforcing its provisions.

Adopted as amended by the Reference Committee (page 416)

#14

Revision Of Medical Practice Act

From the Passaic County Medical Society

(Reference Committee "E")

Whereas, many and basic changes in the practice of medicine in New Jersey have brought about an acute need for revision and modernization of the State Medical Practice Act; and

Whereas, it is of vital importance that these revisions adequately meet the needs of modern medical practice and of the public it serves; and

Whereas, at the 1967 meeting of the House of Delegates a resolution was passed to proceed with the revision of the Medical Practice Act; now therefore be it

RESOLVED, that the Passaic County Medical Society go on record in support of legislative efforts to revise the Medical Practice Act and to categorize all paramedical modalities as they relate to the ethical practice of medicine; and be it further

RESOLVED, that the Council on Legislation of The Medical Society of New Jersey participate fully and actively in all phases of the deliberations and activities of the Commission on Senate Joint Resolution #10; and be it further

RESOLVED, that all specialty groups of The Medical Society of New Jersey scrutinize all pertinent sections of the final draft to be given to the commission, with provision for insertion of appropriate alternatives where a specialty society or societies deems them advisable.

Not adopted because its major substantive provisions are included in Resolution #13 as amended (page 417)

#15

Temporary Licensure for Approved Internship and Residency Programs

From the Middlesex County Medical Society

(Reference Committee "E")

Whereas, interns and residents training in approved programs within hospitals in New Jersey have provided and continue to provide significant medical service to the practicing physicians, their private patients, and the community; and

Whereas, existing law and practice make it impossible for house officers to prescribe for patients, sign death certificates, and perform other routine functions in the hospital setting, due to present restrictive licensure laws; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge re-examination of the licensure status of interns and residents obtaining training in AMA-approved hospital training programs within the state with a view toward a mechanism for temporary licensure on joint application from the institution and the house officer, not to exceed one year, and renewable annually.

Not adopted. The Reference Committee recommended that the President of The Medical Society of New Jersey, after consultation with the Board of Trustees, appoint a committee to study this problem. (page 420)

#16

Uniform Anatomical Gift Act

Arthur Winter, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, the Uniform Anatomical Gift Act passed the New Jersey Assembly on 24 March 1969 as bill A-137; and

Whereas, the Council on Legislation of The Medical Society of New Jersey has already approved bill A-137; and

Whereas, this bill, to authorize gifts of all or part of a human body after death for advancement of medical science or replacement or rehabilitation of diseased or worn out parts of organs, is of vital importance to the physicians of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey give bill A-137 active support to assure its passage in the Senate and its being signed into law; and be it further

RESOLVED, that The Medical Society of New Jersey contact personally each and every Senator, and the Governor, explaining our all-out support for, and the tremendous importance of, this measure for the advancement of medical science.

The following substitute resolution was adopted for Resolution #16:

Whereas, the Uniform Anatomical Gift Act passed the New Jersey Assembly on 24 March 1969 as bill A-137; and

Whereas, The Council on Legislation of The Medical Society of New Jersey has already approved bill A-137; and

Whereas, this bill — to authorize gifts of all or part of a human body after death for advancement of medical science, or replacement or rehabilitation of diseased or worn out parts of organs — is of vital importance to the physicians of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey give bill A-137 active support to further its passage in the Senate and its being signed into law.

Adopted as amended by the House (page 420)

#17

School Bus Safety

Sheldon N. Feinberg, M.D., Delegation from Bergen County

(Reference Committee "G")

Whereas, the School Child Health Committee of the Bergen County Medical Society, having considered at length the matter of school bus safety, has arrived at specific recommendations approved by the Bergen County Medical Society and attached hereto; now therefore be it

RESOLVED, that The Medical Society of New Jersey give due consideration to said recommendations and take those steps, including instigation and pursuit of proper legislation, necessary to implement said recommendations.

Foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey give due consideration to said recommendations and take those steps, including instigation and pursuit of proper legislation, as necessary to implement the principles of said recommendations. (page 425)

STATEMENT

Bus Safety Recommendations of the Committee on School and Child Health of the Bergen County Medical Society

1. *The use of trained student or adult monitors* . . . At least one (preferably two) older children, or adults are suggested. These individuals would assist in the evacuation of children through emergency doors. Driver injury or fire in the bus would otherwise leave children unattended, liable to panic, likely to perish.

2. *Bus evacuation drills* . . . These should be monitor assisted and conducted each month. Each child should be required to open the emergency door — without assistance — twice each year.

3. *Road-crossing drills to and from the stopped bus* . . . These should be conducted at least twice a year. Children must be taught to look carefully, and to thereafter cross the street rapidly.

4. *Stand-off guard for front of bus* . . . Children cross the street in front of the school bus. Unless children cross well in front, they may not be observed by the driver. A child who stoops momentarily may be run over. It is recommended that a simple, suitable guard be designed to protect against this hazard. Details of construction may be discussed with members of this committee.

5. *Side gate which swings down from the bus to protect children who cross the street* . . . It is recommended that a six to eight foot, red and white, strobe lighted side gate be employed to close off the oncoming traffic lane. The use of a concomitant warning bell is also recommended. Details of construction may be discussed with members of this committee.

6. *Emergency exists — at least four full size exits are recommended for all new school buses* . . . Emergency doors should lock automatically during movement of the bus and should unlock automatically when the bus is stopped. Steps, one or two, are recommended, as the height (2½ to 3 feet) to ground is a hazard for small children.

7. *Bus interiors:*

a. Recommend that existing buses have seat bars and other dangerous protrusions properly padded (at least ½ inch of cushioning material).

b. Recommend the recessing of knobs, handles, hooks and other protrusions on all new buses.

c. Recommend a seat height of at least 28 inches on all new buses. Also recommend that this seat back be well padded.

d. Recommend padded 28 inch high barrier between the first passenger seat and the front of all new buses — to prevent hurling of first seat passengers against windows, front door bar, dashboard instruments, etc.

8. *Non-rupturing gas tanks on all buses* . . . To prevent ever present danger of fire.

9. *Light vehicles used for pupil transportation* . . . This type of vehicle presents additional hazards not present in the larger, sturdier school buses. Specifically, it is recommended that there be protection against pupil ejection and against vehicle roll-over hazards. For these reasons, seat belts and a vehicle roll bar are recommended for light vehicles.

10. *Inspection of Buses* . . . Bi-annual inspection of school buses at inspection stations is not deemed sufficient. It is recommended that detailed spot checks be conducted without advanced notice. These examinations should be performed in the bus yard.

11. *Bus Drivers:*

a. Psychological tests are already prescribed. A copy of results should be presented to the school psychologist or psychiatrist so that he can attest to the emotional competency of drivers within his own school district. It should be noted that the local Board of Education has clear responsibility and liability in this regard. It is further recommended that the Board of Education should therefore receive written endorsement by the school psychologist or psychiatrist of each bus driver who is to receive a permanent license.

b. Driver age limit — age 60 years — since reaction time decreases with age.

c. No driver with a history of significant motor or mental handicap or with chronic debilitating disease should be permitted a bus driver's license. Specifically, licenses should not be granted to those candidates who have a history of cardiac disease, chronic respiratory disease (asthma, emphysema, etc.), stroke, epilepsy or other debilitating neurological disorder.

d. Driver must use seat belt when vehicle is in operation.

Resolution adopted as amended by the House (page 425)

#18

Solicitation and Commercial Advertising of a Medical Specialty by Lay Corporations in AMA Publications

From the Middlesex County Medical Society

(Reference Committee "A")

Whereas, the AMA Board of Trustees voted last fall to open all AMA publications to solicitations and commercial advertising of a medical specialty (pathology) by lay corporations; and

Whereas, physicians, by long tradition, are forbidden any activities characterized by self-laudation and solicitation, both of which are essential to commercial advertising; and

Whereas, this Trustee policy encourages the practice of medicine by lay corporations, and promotes solicitation, in violation of all codes of medical ethics; and

Whereas, this Trustee policy, adopted without consulting the House of Delegates, will set a precedent for regional, state and other medical journals, will spread to other fields of medicine and will lower standards of patient care; now therefore be it

RESOLVED, that The Medical Society of New Jersey

(1) reaffirms medicine's traditional opposition to the practice of medicine by lay corporations, to solicitation of patients, and to commercial advertising of the practice of medicine, and

(2) requests New Jersey's AMA Delegates to oppose this new AMA Trustee policy vigorously at the AMA Convention in New York City in July, 1969.

Not adopted. The Reference Committee recommended that this resolution be referred to the Judicial Council for opinion and that a copy of the resolution and opinion be supplied the Chairman of the New Jersey Delegation to the AMA meeting in July. (page 410)

#19

MSP-HSP Coverage for Psychiatric Patients

From the Morris County Medical Society

(Reference Committee "C")

Whereas, it is generally conceded that it is desirable for psychiatric care to be rendered as part of total patient care; and

Whereas, psychiatric disorders by their very nature are prolonged over an extended period of time; and

Whereas, psychiatric therapeutic procedures have become more frequent in general hospital practice; and

Whereas, the Hospital Service Plan of New Jersey and the Medical-Surgical Plan of New Jersey have not provided for such extended treatment; and

Whereas, the usual time limitations imposed by these plans are most often too brief; and

Whereas, these plans have questioned payment during therapeutic brief leaves from hospitals; now therefore be it

RESOLVED, that The Medical Society of New Jersey engage in discussion with the Hospital Service Plan of New Jersey and the Medical-Surgical Plan of New Jersey with a view to provide adequate insurance coverage for patients with psychiatric diagnoses.

Foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey engage in discussion with the Hospital Service Plan of New Jersey and the Medical-Surgical Plan of New Jersey with a view to provide adequate insurance coverage for patients with psychiatric diagnoses while under the care of a physician.

Adopted as amended by the Reference Committee (page 414)

#20

Standardized College Health Report Form

From the Camden County Medical Society

(Reference Committee "G")

Whereas, ever increasing demands are placed on the physician for filling out forms; and

Whereas, colleges are now demanding physical examinations concurrent with receipt of applications for admission; and

Whereas, a review of the forms used by the many colleges vary in such degree that it creates an extremely burdensome task on the examining physician; and

Whereas, all pertinent data could be obtained by a single standardized form for all colleges; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey instruct its delegates to the American Medical Association, at the meeting in New York in July 1969, to endorse a resolution urging that the American Medical Association, in conjunction with the American College Health Association, set up a single standardized form and instruct all colleges that this is the form to be used.

Adopted (page 425)

#21

Governor's Study Group Regarding the State Mental Health Program

From J. Lloyd Morrow, M.D., Delegate from Passaic County
Avrohm Jacobson, M.D., Delegate from Monmouth County
From Eugene V. Resnick, M.D., Delegate from Bergen County

(Reference Committee "F")

Whereas, precipitate action by the Board of Control and the Commissioner of Institutions and Agencies does not produce constructive changes; and

Whereas, in the past few weeks newspaper reports, political activity and official actions of the representatives of State government have acted to discredit certain professionals in the field of mental health; and

Whereas, some of these actions may be partly politically motivated rather than entirely based on the true need to further the care of our unfortunate citizens who by reason of illness have become recipients of care in mental institutions; and

Whereas, it is the opinion of this group that the present bureaucratic organization does not lend itself to the most efficient and most beneficial care of these patients; and

Whereas, it has been the experience of other states that a more adequate program is available and operable; and

Whereas, a study group appointed by the Governor to make specific recommendations in this critical community problem would be more able to submit a definite program; now therefore be it

RESOLVED, that in the interest of providing continuing care and a proper orderly transition, any action presently under consideration be held in abeyance; and be it further

RESOLVED, that The Medical Society of New Jersey petition the Governor to appoint a group of medical consultants, named with the advice and concurrence of the Society's Board of Trustees, to propose a new structure for mental health care in New Jersey.

The foregoing resolution was amended by changing the language of the first paragraph; deleting the third paragraph; and changing the language of the fourth paragraph to read:

Whereas, past action by the Board of Control and the Commissioner of Institutions and Agencies did not produce constructive changes for the Department of Mental Health; and

Whereas, in the past few weeks newspaper reports, political activity and official actions of the representatives of State government have acted to discredit certain professionals in the field of mental health; and;

Whereas, it is our opinion of this group that the present organization does not lend itself to the most efficient and most beneficial care of these patients; and

Whereas, it has been the experience of other states that a more adequate program is available and operable; and

Whereas, a study group appointed by the Governor to make specific recommendations in this critical community problem would be more able to submit a definite program; now therefore be it

RESOLVED, that in the interest of providing continuing care and a proper orderly transition, any action presently under consideration be held in abeyance, and be it further

RESOLVED, that The Medical Society of New Jersey petition the Governor to appoint a group of medical consultants, named with the advice and concurrence of the Society's Board of Trustees, to propose a new structure for mental health care in New Jersey.

Adopted as amended **(page 423)**

#22

Assignment of MSP Payment for Medical Surgical Care

From F. C. Dresdale, M.D., Delegate from Union County

(Reference Committee "C")

Whereas, the basic concept of health insurance is to pay the providers of health care to meet the medical needs of the patient; and

Whereas, the House of Delegates of The Medical Society of New Jersey adopted a resolution in May, 1968 calling upon The Medical Society of New Jersey to recommend to all commercial insurance carriers writing health insurance in New Jersey to make available the assignment of payment for medical and surgical care; and

Whereas, the Blue Shield Plan of New Jersey is competing with these insurance carriers and offering payment for the services of all physicians in New Jersey at a prescribed and set amount; and

Whereas, it is no longer realistic that the continuation of the Blue Shield Plan of New Jersey depends on the membership of the physicians of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend that the Blue Shield Plan of New Jersey make available the asasignment of payment for medical and surgical care and that space be included for such assignment on its insurance forms.

Not adopted (page 414)



House of Delegates — Third Session

#23

House Staff Prescriptions for Welfare Recipients

From Alexander D. Kovacs, M.D., Delegate from Union County

(Reference Committee "E")

Whereas, the Department of Law and Public Safety, Division of Professional Boards, Board of Pharmacy, Section 45-14-14 of Pharmacy Laws and Regulations states that doctors of medicine, without exception, must have a license to prescribe drugs; and

Whereas, county welfare recipients and other indigent and medically indigent hospital patients are given written prescriptions by members of the hospital house staff, these prescriptions being written on hospital prescription blanks and presented to local pharmacies; and

Whereas, the local pharmacies are unable to accept these prescriptions because they are not signed by a licensed physician; and

Whereas, these county welfare recipients and other indigent and medically indigent patients are forced to return to the hospital in order that a licensed physician can countersign the prescription; and

Whereas, the members of the medical staff of hospitals are frequently requested by the house staff to sign or countersign these prescriptions, in most instances they being unfamiliar with the patient or his course of illness; and

Whereas, the hospital physicians give unselfishly of their time and effort to the hospital and its educational programs, and, further, the requirement to countersign these prescriptions is an unnecessary burden; and

Whereas, the members of the house staff of the hospitals are engaged in medical education programs approved by the Council on Medical Education and the respective Residency Review Boards of the American Medical Association, and therefore meet the high professional standards set forth by the American Medical Association; and

Whereas, the ordering of drugs and the writing of prescriptions is a fundamental and integral facet of the practice of medicine; now therefore be it

RESOLVED, that The Medical Society of New Jersey forthwith sponsor legislation to effect recognition and establishment of limited licensure for house officers in hospital educational programs approved by the American Medical Association, thereby granting authorization for these house officers to sign prescriptions which shall be recognized and accepted by pharmacies in the State of New Jersey.

Not adopted. The Reference Committee recommended that the President of The Medical Society of New Jersey, after consultation with the Board of Trustees, appoint a committee to study this problem. (page 420)

#24

Distribution of Perinatal Study Guide to Hospitals

From the Essex County Medical Society

(Reference Committee "G")

Whereas, perinatal mortality and morbidity remain a formidable challenge to society and the medical profession; and

Whereas, the reduction of this tragic toll of life, suffering, and cost to society can only be accomplished by the study and correction of the causative factors responsible for this human wastage; and

Whereas, hospital perinatal conferences have been recommended by the Committee on Maternal and Child Care of the AMA and other related medical organizations as an important instrument of study; and

Whereas, the Committee on Child Health and the Committee on Maternal and Infant Welfare of The Medical Society of New Jersey has jointly designed a practical and workable "Suggested Guide for the Hospital Perinatal Study Conference" which has been effectively used in hospitals in Essex County, as well as to initiate a county-wide program; now therefore be it

RESOLVED, that The Medical Society of New Jersey distribute and recommend for use the "Suggested Guide for the Hospital Perinatal Study Conference" to all hospitals in New Jersey.

The Reference Committee recommended approval of Resolution #24 with the last paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey distribute and strongly recommend to all hospitals in New Jersey the use in whole or in part of the "Suggested Guide for the Hospital Perinatal Study Conference." (page 425)

Tabled **(page 425)**

#25

Medicare Director to Have Clinical Experience

From the Essex County Medical Society

(Reference Committee "E")

Whereas, the Office of the Medical Director for the fiscal intermediary for Part B Medicare has functioned more effectively through a knowledge of the private physician's role; and

Whereas, such knowledge is best obtained from personal experience in the private practice of medicine; and

Whereas, we understand that the present Medical Director for the fiscal intermediary for Part B Medicare will shortly retire; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the fiscal intermediary for Part B Medicare to select as Medical Director one from The Medical Society of New Jersey who has had active clinical experience in the private practice of medicine.

Adopted **(page 421)**

#26

Solicitation and Commercial Advertising of a Medical Specialty by Lay Corporations in AMA Publications

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the AMA Board of Trustees voted last fall to open all AMA publications to solicitation and commercial advertising of a medical specialty (pathology) by lay corporations; and

Whereas, physicians, by long tradition, are forbidden any activities characterized by self-laudation and solicitation, both of which are essential to commercial advertising; and

Whereas, this Trustee policy encourages the practice of medicine by lay corporations, and promotes solicitation, in violation of all codes of medical ethics; and

Whereas, this Trustee policy, adopted without consulting the House of Delegates, will set a precedent for regional, state, and other medical journals, will spread to other fields of medicine and will lower standards of patient care; now therefore be it

RESOLVED, that the Essex County Medical Society:

(1) Reaffirms medicine's traditional opposition to the practice of medicine by lay corporations, and to solicitation, and to commercial advertising of the practice of medicine; and

(2) Requests The Medical Society of New Jersey delegates to oppose this new AMA Trustee policy vigorously at the MSNJ convention in Atlantic City in May 1969; and

(3) Requests these delegates to call on the New Jersey delegation to AMA to reverse this Trustee policy at the July AMA convention in New York City.

Not adopted. The Reference Committee recommended that this resolution be referred to the Judicial Council for opinion and that a copy of the resolution and opinion be supplied to the Chairman of the New Jersey Delegation to the AMA meeting in July. (page 410)

#27

Legislation Concerning Air Pollution Control

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the Division of Clean Air and Water established in 1967 in the State Department of Health has been effectively promulgating and implementing codes designed to abate air pollution and thereby improve the quality of ambient air; and

Whereas, the goals of the Division clearly aim at unremitting progress in solving with celerity the problems of environmental pollution through the utilization of the most advanced technology; and

Whereas, the performance and accomplishment of the Division attest to the efficacy of the existing program; now therefore be it

RESOLVED that The Medical Society of New Jersey disapprove any interference with the continuance of the tempo and quality of the existing program and in consequence urge the defeat of the proposed legislation, Senate Bills 642, 643 and 646.

Not adopted, since MSNJ has already taken a position on these bills: S-642 APPROVED; S-643 and S-646 DISAPPROVED. (pages 350 and 421)

#28

Acceptance of Commercial Advertising

From the Burlington County Medical Society

(Reference Committee "A")

Whereas, a new commercial organization named Medi Card, Inc. has been established to provide patients with a credit card for use in paying physicians' fees for services; and

Whereas, the organization Medi Card, Inc. receives (a) 6 per cent of the physician's fee paid *by the physician* for the guarantee of receiving prompt payment of fees, and (b) a monthly carrying charge on the patient's unpaid balance paid *by the patient;* and

Whereas, such a business arrangement tends to place a stigma of commercialism on the medical profession and, therefore, promotes deterioration of the traditional doctor-patient relationship; and

Whereas, the use of such a medical credit card basically increases the effective cost of medical care to the patient; and

Whereas, the current acceptance of advertising of Medi Card, Inc. in THE JOURNAL of The Medical Society of New Jersey implies endorsement by The Medical Society of New Jersey; and

Whereas, the Judicial Council of the American Medical Association has stated, "The use of bank cards in financing medical fees must, however, be viewed with reserve at the present stage of their development. While patients may not be denied the right to determine matters of their personal budgeting, physicians must not encourage the use of this financing method if in operation it might compromise the ideals of the medical profession or add to the financial burdens of patients;" now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey go on record opposing the endorsement and encouragement of such commercial enterprises as Medi Card, Inc. at the present time; and be it further

RESOLVED, that permission for advertising by Medi Card, Inc., and similar enterprises in THE JOURNAL of The Medical Society of New Jersey and the journals of the component county medical societies not be granted; and be it further

RESOLVED, that an appropriate committee of The Medical Society of New Jersey study this problem and report its findings to the House of Delegates next year.

The foregoing resolution was amended by the Reference Committee by changing the title; the language of paragraphs 5, 7, and 8; inserting a new "Resolved" between paragraphs 7 and 8; and replacing paragraph 9—to read:

THE USE OF MEDICAL CREDIT CARDS

From the Burlington County Medical Society
(Reference Committee "A")

Whereas, a new commercial organization named Medi Card, Inc. has been established to provide patients with a credit card for use in paying physicians' fees for services; and

Whereas, the organization Medi Card, Inc. receives (a) 6 per cent of the physician's fee paid by the physician for the guarantee of receiving prompt payment of fees, and (b) a monthly carrying charge on the patient's unpaid balance paid by the patient; and

Whereas, such a business arrangement tends to place a stigma of commercialism on the medical profession and, therefore, promotes deterioration of the traditional doctor-patient relationship; and

Whereas, the use of such a medical credit card basically increases the effective cost of medical care to the patient; and

Whereas, the current acceptance of advertising of Medi Card, Inc. in THE JOURNAL of The Medical Society of New Jersey may suggest to the reader endorsement by The Medical Society of New Jersey; and

Whereas, the Judicial Council of the American Medical Association has stated, "The use of bank cards in financing medical fees must, however, be viewed with reserve at the present stage of their development. While patients may not be denied the right to determine matters of their personal budgeting, physicians must not encourage the use of this financing method if in operation it might compromise the ideals of the medical profession or add to the financial burdens of patients;" now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey go on record opposing the use of payment devices such as Medi Card, Inc.; and be it further

RESOLVED, that this decision be communicated by individual letter to the members of The Medical Society of New Jersey as soon as possible; and be it further

RESOLVED, that permission for advertising by Medi Card, Inc., and similar enterprises in THE JOURNAL of The Medical Society of New Jersey and the journals of the component county medical societies in the future not be granted; and be it further

RESOLVED, that any doubtful proposal of this character be referred to the Judicial Council for study and recommendation.

Adopted as amended by the Reference Committee (page 410)

#29

Packaged Disaster Hospital

From Frank R. Schell, M.D., Delegate from Passaic County
(Reference Committee "D")

Whereas, the State of New Jersey is particularly vulnerable to an initial atomic onslaught; and

Whereas, the packaged disaster hospital stands as the first line of medical defense in the immediate post-attack; and

Whereas, the Government considers attacks sufficiently possible to advocate $5 billion as an initial investment in an anti-ballistic missile system; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as being opposed to the proposed budgetary cut which will place the citizenry of this State and the rest of the nation in the position of unjustifiable jeopardy, and that our representatives in congress be so informed.

Foregoing paragraph amended by the Reference Committee to read:

RESOLVED, that The Medical Society of New Jersey go on record as being opposed to the proposed budgetary cut in the Emergency Health Service Program because it would reduce the effectiveness of the hospital reserve disaster inventory program, thus placing the citizenry of this State and the rest of the nation in the position of unjustifiable jeopardy, and that our representatives in Congress be so informed.

Adopted as amended by the Reference Committee (page 415)

#30

Abortion

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "A")

Whereas, there is a governor's study commission on abortion, which has the aim of suggesting methods of liberalizing the laws on abortion; and

Whereas, it is hoped that the New Jersey State Legislature will pass some liberalizing legislation; and

Whereas, there is a resolution now before The Medical Society of New Jersey urging the incorporation in any state legislation of a rule which would absolve any physician or hospital from being required to perform an abortion or abortions; and

Whereas, the real problem about abortions is not studied nor even considered with all of the commissions and legislation, and that problem is the one of illegal abortions done on healthy married women who just do not want a pregnancy (it is estimated that 80 per cent of all illegal abortions are in this category); now therefore be it

RESOLVED:

a) That any future abortion commissions have an equal number of women as men (the women are the consumers, so to speak) and that said women be representative of all religious and ethical as well as states of matrimony factions; and

b) That it be made a rule that all physicians and hospitals caring for pregnant women be required to inform, perhaps in writing with signature of the patient being obtained, all pregnant women who might well be running a risk of their own health or might be bearing an injured child from the known high-frequency causes for such injury of her right to have an abortion and her possible need for such, even though the particular physician and particular hospital would not be required to actually perform said needed abortion. The physician and hospital would be required, however, to aid said pregnant woman in making arrangements for an abortion if she should so desire.

Not adopted, because it is so widely at variance with the Society's recently established official position and policy. (page 411)

#31

Medicaid Fiscal Intermediary

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "E")

Resolution #31 was withdrawn by the sponsor (page 421)

REFERENCE COMMITTEES

Reference Committee "A"

Harold L. Colburn, Jr., M.D., Chairman

Reference Committee "A" met on Sunday 18 May 1969, with all members present: Doctors Robert C. Anderson, C. Spencer Davison, Philip J. Kunderman, Daniel J. O'Regan, and the chairman. Approximately 37 delegates and members were present to discuss the various items under consideration.

1. **President** (page 293)

The Committee *recommends* that the report be approved.

Adopted

2. **Board of Trustees – Items** (page 304)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee *recommends* that the report be approved.

Adopted

a. **Implementation of Constitutional Amendment Affecting Membership of Elected Trustees on the Board** (page 304)

The Committee *recommends* that the report be approved.

Adopted

b. **Joint Conference with Presidents of Component Societies** (page 306)

The Committee *recommends* that the report be approved.

Adopted

c. **Professional Liability Panel** (page 306)

The Committee *recommends* that the report be approved.

Adopted

3. **Secretary** (page 296)

The Committee *recommends* that the report be approved.

Adopted

4. **Judicial Council** (page 315)

The Committee *recommends* that the report be approved.

Adopted

5. **Executive Director** (page 318)

The Committee *recommends* that the report be approved.

Adopted

6. **Credentials** (page 323)

The Committee *recommends* that the report be approved.

Adopted

The Reference Committee thanks all the officers and committees for the great deal of hard work which has gone into the preparation of their reports.

7. **Resolutions:**

a. **Assimilation of Osteopaths** – Resolution #1 (page 386)

b. **Assimilation of Osteopaths** — Resolution #2 (page 387)

These resolutions were exhaustively discussed by some 15 to 20 members in regular meeting as well as by your Committee in executive session. This Committee favors the principle that osteopaths be made eligible for membership in this Society. It is the considered opinion of this Committee, however, that legislative and other action necessary to accomplish this objective should not be initiated until such time as it appears that there is measurable evidence of interest and willingness on the part of a substantial number of osteopaths to join The Medical Society of New Jersey. This matter is obviously of such significance that it should be investigated thoroughly over such period of time as would provide assurance that all aspects of the problem are evaluated.

For the above reasons, your Committee *recommends* that Resolutions #1 and #2 be not adopted at this time, and further *recommends* that a special committee be established by the Board of Trustees to study this matter in depth and detail and to submit its report and recommendations to the 1970 House of Delegates.

Adopted

c. **Classification of Membership** — Resolution #3 (page 387)

The Reference Committee sees no advantage to be gained by changing the classification of membership in The Medical Society of New Jersey and therefore *recommends* approval of Resolution #3 (page 388)

Adopted

d. **Relative Value Index** — Resolution #4 (page 389)

The Reference Committee *recommends* approval of Resolution #4 with the following amendment (indicated by italics) to the last paragraph:

RESOLVED, that this, the 1969 House of Delegates, lift from the table consideration of a Relative Value Index and direct the Board of Trustees to have prepared *by the Council on Medical Services* a revised and updated Relative Value Index to be presented to the House of Delegates for action *at its next annual meeting.*

Adopted

e. **Solicitation and Commercial Advertising of a Medical Specialty by Lay Corporations in AMA Publications** — Resolution #18 (page 399)

f. **Solicitation and Commercial Advertising of a Medical Specialty by Lay Corporations in AMA Publications** — Resolution #26 (page 405)

Resolutions #18 and #26 were considered together because of their practical identity of substance and purpose. Study of them developed the realization, pointed out by the Chairman of the Judicial Council, that their adoption by the House would involve the House in the formulation of opinions in the area of ethics and professional conduct, which area, under MSNJ's Constitution and Bylaws, is exclusively assigned to the Judicial Council.

Accordingly, your Committee *recommends* that these resolutions be not adopted but be referred to the Judicial Council with a request for early consideration and opinion concerning the ethical points involved. It further *recommends* that copies of the resolutions be supplied to the Chairman of New Jersey's Delegation to the AMA to be used, in conjunction with such opinion as our Judicial Council may render, in their caucus at the AMA meeting in New York City next July.

Adopted

g. **Acceptance of Commercial Advertising** — Resolution #28 (page 406)

This resolution was amended (indicated by italics) as follows, with the consent of its sponsor:

That the title be changed to read:

"The Use of Medical Credit Cards"

The resolution from the 5th "Whereas" on has been amended to read as follows:

Whereas, the current acceptance of advertising of Medi Card Inc., in THE JOURNAL of The Medical Society of New Jersey *may suggest to the reader* endorsement by The Medical Society of New Jersey; and

Whereas, the Judicial Council of the American Medical Association has stated, "The use of bank cards in financing medical fees must, however, be viewed with reserve at the present stage of their development. While patients may not be denied the right to determine matters of their personal budgeting, physicians must not encourage the use of this financing method if in operation it might compromise the ideals of the medical profession or add to the financial burdens of patients;" therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey go on record opposing the *use* of *payment devices such* as Medi Card Inc.; and be it further

RESOLVED, that this decision be communicated by individual letter to the members of The Medical Society of New Jersey as soon as possible; and be it further,

RESOLVED, that permission for advertising by Medi Card, Inc., and similar enterprises in THE JOURNAL of The Medical Society of New Jersey and the journals of the component county medical societies *in the future* not be granted; and be it further

RESOLVED, that any doubtful proposal of this character be referred to the Judicial Council for study and recommendation.

The Committee *recommends* that the resolution, as amended, be approved.

Adopted

h. **Abortion** – Resolution #30 (page 408)

Resolution #30 was painstakingly considered. Its sponsor deleted the first two paragraphs of the "Resolved" during his appearance before the Committee.

The "Resolved" section now reads:

a) That any future abortion commissions have an equal number of women as men (the women are the consumers, so to speak) and that said women be representative of all religious and ethical as well as states of matrimony factions; and

b) That it be made a rule that all physicians and hospitals caring for pregnant women be required to inform, perhaps in writing with signature of the patient being obtained, all pregnant women who might well be running a risk of their own health or might be bearing an injured child from the known high-frequency causes for such injury of her right to have an abortion and her possible need for such, even though the particular physician and particular hospital would not be required to actually perform said needed abortion. The physician and hospital would be required, however, to aid said pregnant woman in making arrangements for abortion if she should so desire.

Your Committee discussed this resolution extensively in executive session. It concluded that this resolution basically contravenes the policy position taken by the 1968 House of Delegates after protracted preparation and deliberation. That position has been officially promulgated and has been given to the Legislative Commission presently studying the Abortion Statutes of New Jersey.

Your Committee also points out that Resolution #30 is diametrically opposed to the following two statements supplied by the Board of Trustees to the Legislative Commission in further delineation of the Society's policy position:

(1) No person shall be required to perform or participate in medical procedures which

result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or any other recriminatory action against him; and

(2) No hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit such procedures shall not be grounds for civil liability to any person, hospital, or institution nor a basis for any disciplinary or other recriminatory action against it by the state or any person;

In the light of the foregoing, your Committee has concluded that Resolution #30 should not be considered at this time because it is so widely at variance with the Society's recently established official position and policy. It therefore *recommends* that Resolution #30 be disapproved.

Adopted

Reference Committee "B"

Charles Cunningham, M.D., Chairman

Reference Committee "B" met on Sunday, 18 May 1969, with all members present: Doctors Frederick W. Durham, John A. Kinczel, Emil A. Kratzman, Henry O. vonDeilen, and the chairman. Approximately 10 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

a. **Academy of Medicine of New Jersey** (supplement #1 page 311)

The Committee *recommends* approval of the report as submitted. The Committee also *recommends* that the Academy be complimented on its work on the roving symposia and section meetings and hopes that the good work will be continued.

Adopted

b. **Health Facilities Planning Council for New Jersey** (page 307)

The Committee *recommends* approval of the report as submitted. It is the opinion of the Reference Committee that the $5,000 contribution authorized for the fiscal year 1969-70 should be only on an annual basis and that each year the work of the Health Facilities Planning Council be reviewed before any further contributions are made.

Adopted

2. **Treasurer** (page 297)

The Committee *recommends* approval of the report as submitted and commends the Treasurer on his detailed report, especially the last page which included the investments and income earned. It was noted that there is a marked increase in the per cent of return over previous years.

Adopted

3. **Finance and Budget** (page 324)

The Committee *recommends* approval of the report as submitted. The Chairman of the Committee on Finance and Budget, Treasurer, and Business Manager were present to answer the many inquiries. It was noted that the dues for the next fiscal year will be $55. The Reference Committee appreciated the receipt of copies of the budget prior to the meeting and *recommends* that this procedure

be continued and that copies be supplied to members of Reference Committee "B" at least 10 days in advance of the annual meeting.

Adopted

4. **Medical Student Loan Fund** (page 335)

The Committee *recommends* approval of the report as submitted. The Committee also *recommends* that the loans be continued for those eligible students who require them.

Adopted

5. **Publication** (page 338)

The Committee *recommends* approval of the report as submitted.

Adopted

6. **Project Hope/Vietnam** (page 372)

The Committee *recommends* approval of the report as submitted.

Adopted

Reference Committee "C"

John J. McGuire, M.D., Chairman

Reference Committee "C" met on Sunday, 18 May 1969, with all members present: Doctors James S. D. Eisenhower, Jr., Dorothy K. Klughaupt, Blackwell Sawyer, Dorsett L. Spurgeon, and the chairman. Approximately 43 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

a. **AID Program** (supplement #1, page 312)

The Committee *recommends* approval of this report.

Adopted

b. **Health Insurance for Pregnancy** (page 307)

The Committee *recommends* approval of this report.

Adopted

c. **MSP Board of Trustees** — Nominations (page 305)

The Committee *recommends* approval of this report.

Adopted

d. **Standardized Insurance Forms** (page 308)

Since the House of Delegates of the AMA in Resolution #72 of 1968 conformed with our Resolution of 1968, this report was interpreted as informative.

The Committee *recommends* approval of this report.

Adopted

2. **Medical-Surgical Plan of New Jersey** (page 375)

The Annual Statement of the Medical-Surgical Plan of New Jersey was reviewed and accepted as informative.

The Committee *recommends* approval of this report.

Adopted

3. **Medical Defense and Insurance** (page 327)

Reference Committee "C" noted that Fred A. Mettler, M.D., Chairman of the Committee on Medical Defense and Insurance and Ernest C. Hillman, Jr., M.D., Vice-Chairman are retiring. These gentlemen should be especially commended for the work of their Committee and for the completeness of their final report.

The Committee *recommends* approval of this report.

Adopted

4. **Retirement Plan for Physicians** (page 373)

Several retirement plans were discussed and one was presented in great detail.

The Committee *recommends* approval of this report.

Adopted

5. **Resolutions:**

a. **Discontinuance of AID Certification** — Resolution #5 (page 389)

The Committee feels that this procedure has greatly assisted utilization committees in determining and in assaying the average patient day.

The Committee *recommends* disapproval of this Resolution.

Adopted

b. **MSP-HSP Coverage for Psychiatric Patients** — Resolution #19 (page 400)

Reference Committee "C" amended (indicated by italics) the "RESOLVED" portion of Resolution #19 to read:

"RESOLVED, that The Medical Society of New Jersey engage in discussion with the Hospital Service Plan of New Jersey and the Medical-Surgical Plan of New Jersey with a view to provide adequate insurance coverage for patients with psychiatric diagnoses *while under the care of a physician.*"

The Committee *recommends* approval of the amended Resolution #19.

Adopted

c. **Assignment of MSP Payment for Medical Surgical Care** — Resolution #22 (page 402)

Your Committee feels approval of this Resolution could endanger the life span of MSP. Furthermore, MSP is an enabling plan with 77 per cent of the physicians in New Jersey participating. Forty per cent of the subscribers have a total income of less than $7,500 where husband and wife are employed.

The Committee *recommends* disapproval of Resolution #22.

Adopted

Bibliography On Tissue Transplantation

The Public Health Service has just released a 58-page brochure describing works on the emotional and social aspects of tissue transplantation. It lists 176 articles on the subject, and after each listing is a compact summary of the work. As long as the free supply lasts, a doctor may obtain a copy *gratis* from the NIMH Clearing House at Chevy Chase, Maryland 20203. Copies are also available at 40 cents each from the U.S. Government Printing Office, Washington, D.C. 20402. Ask for Public Health Service Publication #1838.

Reference Committee "D"

Paul J. Kreutz, M.D., Chairman

Reference Committee "D" met on Sunday, 18 May 1969, with all members present: Doctors George L. Benz, Vincent H. Gillson, Elmer L. Grimes, John A. Sakson, and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** – Items

a. **Hospital Chaplaincy Program** (page 308)

The Committee *recommends* approval of the Board's report of this item.

Adopted

2. **Medical Education** (page 334)

Reference Committee "D" recommends that approval be given to the report of the Committee on Medical Education, and further *recommends* that:

The Chairman of the Committee on Medical Education extend an invitation through the deans of the two New Jersey medical colleges to the medical students to attend the Annual Meeting in 1970 of The Medical Society of New Jersey and to visit the exhibits and scientific sessions. It is suggested that there be a special student registration with a distinctive student badge.

Adopted

3. **Emergency Medical Care** (page 370)

Reference Committee "D" *recommends* approval of the report of the Committee on Emergency Medical Care, and further *recommends* that The Medical Society of New Jersey continue to support the program of training emergency room physicians and paramedical personnel.

Adopted

4. **Medicine and Religion** (page 371)

Reference Committee "D" discussed the report of the Committee on Medicine and Religion and *recommends* that it be approved as submitted.

Attention is directed to the last paragraph of the report wherein hope is expressed that at the Fall 1969 Conference of Presidents of component societies and the Board of Trustees of MSNJ, time be allotted to include discussion of the subject of medicine and religion.

Adopted

5. **Traffic Safety** (page 374)

The report of the Committee on Traffic Safety was discussed, and Reference Committee "D" *recommends* that the report be approved with the following modification (in italics):

The last sentence in paragraph three of the report be revised to read as follows: "This advisory panel should consist of professional practitioners *in the respective fields.*"

Adopted

6. **Resolutions:**

a. **Packaged Disaster Hospital** – Resolution #29 (page 407)

The Committee *recommends* approval of Resolution #29 submitted to the House of Delegates by Dr. Frank R. Schell of Passaic County, with the following changes (indicated by italics) in the "Resolved" portion of the resolution – which was made only for purposes of clarification; namely:

RESOLVED, that The Medical Society of New Jersey go on record as being opposed to the proposed budgetary cut *in the Emergency*

Health Service Program because it would reduce the effectiveness of the hospital reserve disaster inventory program, thus placing the citizenry of this State and the rest of the nation in the position of unjustifiable jeopardy, and that our representatives in Congress be so informed.

Adopted

Reference Committee "E"

Elbert H. Pogue, M.D., Chairman

Reference Committee "E" met on Sunday, 18 May 1969, with the following members present: Doctors Isaac N. Patterson, Leopold E. Thron, Eugene J. Tyrrell, and the chairman. Approximately 61 delegates and members were present to discuss the various items under consideration. Doctor William Chase acted as sergeant-at-arms. Also present were Mr. E. Powers Mincher, acting legal counsel of The Medical Society of New Jersey and Mr. Vincent A. Maressa the Executive Assistant to the Executive Director.

1. **Board of Trustees** — Items

a. **Commission to Study Abortion Statutes** (page 308)

Resolution #6 (page 390) was considered at the same time as it treats the same matter. The major provisions of Resolution #6 were covered by the action of the Board of Trustees on 27 November 1968 as more particularly described in the Boards' annual report to this House of Delegates (page 308). It is *recommended* that the Trustees' report be approved. However, it is further *recommended* that Resolution #6 be approved because it is more inclusive in suggesting guidelines for possible further relevant action.

Adopted

Reference Committee "E" wishes to emphasize to the House of Delegates that paragraph one in the Board of Trustees' report and in Resolution #6 specify persons involved directly (physicians) and that paragraph two in the Trustees' report and in Resolution #6 specify the hospital, hospital directors, and hospital governing bodies involved.

The Committee *recommends* approval of this report.

Adopted

b. **Mandatory Inclusion of Physicians As Members of Hospital Governing Bodies** (page 309)

The Reference Committee *recommends* approval of this report as submitted.

Adopted

c. **Review of Medical Practice Statutes** (page 309)

This report from the Board of Trustees was considered with Resolution #13 (page 395) from the Bergen County Medical Society and Resolution #14 (page 396) from the Passaic County Medical Society. It was pointed out in the discussion that a committee appointed by the President of The Medical Society of New Jersey in May 1967 at the direction of the 1967 House of Delegates had made available to all component societies an updated version of the Medical Practice Act. At so doing a

request was made of the component societies that they enumerate the areas of concern and transmit their suggestions to the committee by January 1968. Thus far replies have been received from only three component societies. Through the efforts of the Council on Legislation and with the approval of the Board, several of the revisions incorporated in the three replies have already been introduced and enacted into law. They are:

1) privileged communications,
2) x-ray technicians law,
3) licensing of foreign physicians who upon declaration of intent to become citizens have been duly admitted to and passed the New Jersey Medical Licensure Examination.

Therefore, Reference Committee "E" *recommends* that the Trustees' report be approved and that Resolution #13 be approved with the last paragraph amended (indicated by italics) to read:

RESOLVED, that The Medical Society of New Jersey through the Special Committee to Review Statutes Related to the Practice of Medicine and Surgery in New Jersey, the Legislative Analyst, the Council on Legislation and whatsoever other pertinent avenue, do everything in its power to encourage the framing and passing into law of *needed revisions to the* Medical Practice Act consonant with the principles of the best in modern health care for the people of our state and providing adequate and effective means for enforcing its provisions.

This amendment was agreed to by the sponsors of this resolution. The Reference Committee *recommends* the adoption of this portion of the report.

Adopted

The Committee *recommends* disapproval of Resolution #14 because its major substantive provisions are included in Resolution #13 as amended.

Adopted

d. **Concerning Welfare Recipient** (page 310) and **Resolutions #7 and #8 of the 1968 House** — Supplemental #2 (page 313)

Resolution #7, adopted by the 1968 House, urged that the Medical Society of New Jersey petition the State Department of Institutions and Agencies to establish the principle throughout New Jersey that diagnostic, laboratory, and medical specialty services be allowed when found necessary by the treating physician, and that payment for such services be on a realistic, reasonable, and customary fee basis.

Resolution #8, adopted by the 1968 House, directed that The Medical Society of New Jersey petition the New Jersey State Department of Institutions and Agencies to bring the physicians' fees for services paid by all welfare boards in the state up to a realistic level on a reasonable and customary fee basis.

Both resolutions further resolved that the Society deal directly with the Department of Institutions and Agencies to embody these principles in their present and future plans, ". . . so that there will be no mistake of our intent or resolve and so that these tenets be effected by May 1969."

The Society has through the year emphasized and urged the effectuation of these resolutions with the Department of Institutions and Agencies. The most recent utterance by the Department in this connection was contained in a letter dated 14 May 1969, addressed to the Secretary of The Medical Society of New Jersey's Board of Trustees by Lloyd W. McCorkle, Commissioner of Institutions and Agencies.

Commissioner McCorkle states:

". . . the major development which has occurred during the last year, that is relevant to Resolutions #7 and #8 of your Society, was the enactment of Chapter 413 of the Laws of 1968, generally referred to as 'Medicaid,' which will become operational 1 January 1970.

Under this law, the County Welfare Boards, and the State Division of Public Welfare as well, will be relieved of authority and responsibility for regulating the amount, kind, and rates of allowances for all elements of medical and paramedical care furnished to welfare recipients by any facility or practitioner. The new program will be administered on a uniform statewide basis by a new Division of Medical Assistance and Health Services established within this Department.

The specific recommendations contained in the resolutions referred to, as well as many others of similar concern to your Society, will be deliberated in the course of the next few months by the Medical Advisory Council and the various subsidiary technical Advisory Committees which are now in the process of being created as part of the organizational structure for implementing the Medicaid program."

The Committee *recommends* approval of this portion of the report.

Adopted

2. **Legislation** (page 342) and supplemental #1 (page 350)

The Committee calls to the attention of the House of Delegates that the Council on Legislation under the leadership of its Chairman Doctor Jesse McCall, has reviewed and acted on an almost unbelievable number of bills in the past year. The Committee congratulates and thanks Doctor McCall and his Council and our legislative analyst for a job well done. One has but to read the Council's report to get an idea of the volume of work done and the many problems faced during the past year.

The Committee *recommends* the adoption of this report.

Adopted

3. **Medical Services** (page 353)

There was no discussion of this report at the general meeting of Reference Committee "E". However, in considering the report, the members of the reference committee call to the attention of the House of Delegates that portion of Doctor Collins' report entitled "Utilization of Physicians' Services Under Part B of Medicare," and I quote in part from the annual report:

"The fiscal intermediary appeared before the Council and requested their endorsement of certain utilization guidelines. After studying this entire area in minute detail it was the considered opinion of the Council that to state that a man has seen a patient more often than is necessary and has billed accordingly is, in fact, to question his ethical deportment and the propriety of his bill. We therefore recommended, and the Board of Trustees approved, that:

1) When the Medicare carrier, after the due consultation with its medical advisors, feels that a question of professional conduct or ethical deportment is at issue, it be advised to process its complaint through the judicial mechanism as the proper agency under the Bylaws of MSNJ (Chapter VII).

2) MSNJ not endorse Prudential's preparation of guidelines, nor encourage Prudential to prepare them unilaterally.

In spite of the recommendations of the Council as expressed concerning preparation of guidelines in a unilateral matter, it appears that Prudential has acted otherwise.

The Committee *recommends* that a special committee be appointed by the President of The Medical Society of New Jersey to investigate this matter after a suitable sampling of cases is secured from the utilization review committees of component societies. It is emphasized that such cases are not to include those in which the fiscal intermediary has filed a complaint with the judicial committee of a component society.

Adopted

4. **Occupational Health, Workmen's Compensation, and Rehabilitation** (page 355)

This report was discussed in detail. The Committee *recommends* approval of this report.

Adopted

5. **Resolutions:**

a. **Chiropractic** — Resolution #7 (page 390)

The Committee cognizant of the fact that (1) future licensure of chiropractors may legally be banned by legislative action, but not the practice of presently licensed chiropractors, and that (2) two commissions have been proposed, one by the Governor and one by the Legislature to study, evaluate and make recommendations concerning the effectiveness of existing laws, rules and regulations relating to those licensed to render services to the ill and infirm and their relevance to contemporary needs and conditions, and that (3) ample opportunity will be afforded this Society to present its position in public hearings, *recommends* that this resolution be disapproved.

The Committee is in unanimous accord with the intent of Resolution #7, but feels that the goals and aims of The Medical Society of New Jersey would best be served by the course of action recommended above.

The Committee *recommends* approval of this report.

Not adopted

Resolution #7 amended by the House to read:

RESOLVED, that The Medical Society of New Jersey is adamantly opposed to the practice and licensing of Chiropractic; and be it further

RESOLVED, that The Medical Society of New Jersey aggressively petition the Governor and Legislature of the State of New Jersey to eliminate the future licensing of Chiropractic in this state; and be it further

RESOLVED, that this resolution be implemented by all means available to The Medical Society of New Jersey until such time as its intent is accomplished.

Adopted as amended by the House

b. **Elimination of Fee Setting by the State in Workmen's Compensation Cases** — Resolution #8 (page 391)

The Committee *recommends* that this resolution be disapproved

The Committee feels that approval of this resolution would result in lessening of the opportunity for the patient concerned to have free choice of physician.

The statement authorized by the Board of Trustees and subsequently published in *The Journal* — Volume 66, No. 1, January 1969 — makes it clear that the course of action indicated in Resolution #8 would be detrimental to the patients concerned and to the physician who at present treats such patients.

Adopted

c. **Legislative Approach to Unjustifiable Professional Liability Suits**—Resolution #9 (page 392)

The Committee is in accord with the objectives of this resolution, but feels that they may best be attained by referring this matter to the Conference Committee with the Bench and Bar, and so *recommends*. The Committee therefore *recommends* that this resolution be disapproved.

Adopted

d. **Limitation of Use of Eye Medication for Diagnostic Purposes** — Resolution #10 (page 393)

This resolution was discussed and its author S. Jerome Greenfield, M.D. spoke in its favor. It was pointed out that the Board of Trustees of The Medical Society of New Jersey on 20 April 1969 had directed ". . . that MSNJ go on record as supporting the aims and objectives of the New Jersey Academy of Ophthalmology and Otolaryngology regarding the use of medication in the eyes with whatever means are necessary to prohibit the use of drugs by optometrists in their examinations for vision defects of their patients.

In an effort to implement the foregoing, the Board also directed that a committee be set up composed of the following: Chairman and

Vice Chairman of the Council on Legislation, two representatives of the Committee on the Conservation of Vision, a representative of the Board of Trustees to serve as Chairman, (Samuel J. Lloyd, M.D.), Acting Legal Counsel, the Executive Director, the Assistant to the Executive Director, and representatives of the New Jersey Academy of Ophthalmology and Otolaryngology."

In view of the action already taken by the Board of Trustees, it is felt by the Committee that no further action is indicated at this time. Although it approves in principle of the content of the resolution, the Committee *recommends* that it be not adopted.

The Committee *recommends* adoption of this portion of its report.

Adopted

e. **Negligence Actions**—Resolution #11 (page 394)

This resolution was discussed in detail and it is felt that the aim expressed in this resolution will best be served by referring this matter to the Conference Committee with the Bench and Bar and Reference Committee "E" so *recommends.*

The Committee therefore *recommends* that this resolution be disapproved.

Adopted

f. **Provision of Comprehensive Health Care** — Resolution #12 (page 394)

The Committee *recommends* approval of this resolution.

Adopted

g. **Temporary Licensure for Approved Internship and Residency Programs** — Resolution #15 (page 396) and **House Staff Prescriptions for Welfare Recipients** — Resolution #23 (page 103)

These two resolutions were considered together since they both deal with limited and temporary licensure of interns and residents. The Committee *recommends* that these two resolutions be disapproved. However, the Committee believes that it may be possible to solve the problems illustrated within existing statutes and to that end the Committee *recommends* that the President of The Medical Society of New Jersey, after consultation with the Board of Trustees, appoint a committee to study this problem and to confer with representatives of the Department of Law and Public Safety, Division of Professional Boards, having jurisdiction in these matters in order to effect a possible solution to problems relating to signing of prescriptions and other necessary documents by interns and residents in hospitals with approved training programs.

Adopted

h. **Uniform Anatomical Gift Act** — Resolution #16 (page 397)

With the approval of the sponsor of Resolution #16, the Committee *recommends* adoption of the following amended resolution (italics):

Whereas the Uniform Anatomical Gift Act passed the New Jersey Assembly on 24 March 1969 as bill A-137; and

Whereas, the Council on Legislation of The Medical Society of New Jersey has already approved bill A-137; and

Whereas this bill — to authorize gifts of all or part of a human body after death for advancement of medical science, or replacement or rehabilitation of diseased or worn-out parts of organs — is of vital importance to the physicians of New Jersey; now therefore be it

RESOLVED, that the Medical Society of New Jersey give bill A-137 active support to further its passage in the Senate and its being signed into law, and be it further

RESOLVED, that efforts be made by the Council on Legislation to have A-137 amended or new legislation introduced that will include the following:

No organ or part of any organ be removed for transplantation unless the following criteria have been confirmed by three impartial physicians who serve independently of the transplant team:

1. No signs of reflexes or muscular activity of any kind.

2. No change in heart rate on eyeball and carotid pressure.

3. No pupillary reflexes and the pupils remain fixed, dilated and do not react to light stimuli.

4. No spontaneous respiration.

5. Flat electroencephalogram without rhythmic response in any lead or channel for at least 2 hours and not due to hypothermia or drug intoxication.

6. No electroencephalographic response to loud noise, pinch, or electrical stimulation at full gain.

7. These tests should be repeated and unchanged at the end of two hours.

The foregoing resolution was amended by the House by tabling the last Resolved, including the listed criteria, and reads:

Whereas, the Uniform Anatomical Gift Act passed the New Jersey Assembly on 24 March 1969 as bill A-137; and

Whereas, the Council on Legislation of The Medical Society of New Jersey has already approved bill A-137; and

Whereas, this bill—to authorize gifts of all or part of a human body after death for advancement of medical science, or replacement or rehabilitation of diseased or worn-out parts of organs—is of vital importance to the physicians of New Jersey; now therefore be it

RESOLVED, that the Medical Society of New Jersey give bill A-137 active support to further its passage in the Senate and its being signed into law.

Adopted as amended by the House

i. **Medicare Director to Have Clinical Experience** – Resolution #25 (page 404)

The Committee *recommends* approval of this resolution.

Adopted

j. **Legislation Concerning Air Pollution Control** – Resolution #27 (page 405)

The Committee brings to the attention of the House of Delegates the fact that the Medical Society of New Jersey, on the recommendation of the Council on Legislation, has already taken a position on Senate Bills 642, 643 and 646. S-642 is approved and S-643 and S-646 are disapproved. In view of the official positions already taken by The Medical Society of New Jersey, the Committee *recommends* that this resolution be disapproved.

The Committee *recommends* adoption of this report.

Adopted

k. **Medicaid Fiscal Intermediary** – Resolution #31 (page 408)

This resolution was withdrawn by its sponsor, John Winslow, M.D. of Essex County.

New Drug Abuse Pamphlets

Because of the rising incidence of drug abuse in the United States, especially among young people, the American Medical Association has published five related pamphlets, "Amphetamines," "Barbiturates," "Marihuana," "LSD," and "Glue Sniffing." These one-page pamphlets answer many of the questions frequently asked about this problem. In addition to describing the effects of these dangerous substances on the body, each pamphlet stresses the hazards of experimentation, the psychologic effects on the users and the legal controls.

Copies are available from the AMA's Department of Health Education. (Order Handling) at 15 cents each; 50 to 99 copies, at 14 cents each.

Reference Committee "F"

Nathan J. Plavin, M.D., Chairman

Reference Committee "F" met on Sunday, 18 May 1969, with all members present: Doctors Francis M. Brower, III, Charles P. Campbell, Nicholas G. Demy, John P. Kengeter, and the chairman. Approximately 29 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

a. **Community Health Week in the Spring** (page 310)

The Committee *recommends* approval of this item.

Adopted

2. **Mental Health** (page 356)

The Committee *recommends* approval of this report.

Adopted, after deletion of paragraphs a and b on page 356.

3. **Alcoholism** (page 357)

The Committee *recommends* approval of this report.

Adopted

4. **Drug Abuse** (page 358)

The Committee commends Doctor Henry A. Davidson for his excellent report and *recommends* approval of this report.

Adopted

5. **Emotional Disorders of Childhood and Adolescence** (page 357)

The Committee amended this report (indicated by italics) with the following addition which was inadvertently left out of the report as printed:

It investigated the problem of 'Dyslexia' and prepared a concise position statement on this subject as follows:

Dyslexia is a reading disability which may have many different and possibly overlapping etiologies. The etiology is obscure and complex. Some of the children with this disability may be suffering primarily from ocular malfunction, and their reading symptom may respond to treatment directed toward this malfunction. Others may be suffering from diffuse brain damage or dysfunction, or from various mental and emotional disorders covering a wide range of diagnostic categories.

Because of the poorly understood nature of the entire field of reading disability and its complexity, it is felt that children with this symptom should have the benefit of a comprehensive diagnostic study, under medical direction. This study would include the contributions of all appropriate disciplines and would include the pediatric, neurologic, psychiatric, and ophthalmologic evaluation of the child.

Children who are examined and treated only from the standpoint of optometric disorders may suffer from the lack of understanding of other factors contributing to their reading disability and from lack of treatment measures directed toward those other factors. One needs to look with caution on all forms of therapy, since there is indication that certain therapies may seem to give good results by their placebo effect or as a consequence of the natural maturation of the child's nervous system.

The Committee *recommends* approval of this report as amended.

Adopted

6. **Mental Retardation** (page 359)

The Committee *recommends* approval of this report.

Adopted

7. **Seizures** (page 360)

The Committee wishes to commend Doctor J. Lloyd Morrow and his Committee for the excellent work they have done.

The Committee *recommends* approval of this report.

Adopted

8. **Public Relations** (page 369)

The Committee *recommends* approval of this report.

Adopted

9. **Resolutions:**

a. **Governor's Study Group Regarding the State Mental Health Program** — Resolution #21 (page 401)

Resolution #21 has been amended as follows:

Paragraph 3 has been deleted and paragraphs 1 and 4 have been amended (indicated by italics) to read:

Whereas, *past* action by the Board of Control and the Commissioner of Institutions and Agencies *did* not produce constructive changes *for the Department of Mental Health;* and

Whereas, it is *our* opinion of this group that the present bureaucratic organization does not lend itself to the most efficient and most beneficial care of these patients; and

Foregoing paragraph amended by the House by deletion of the word "bureaucratic", to read:

Whereas, it is our opinion of this group that the present organization does not lend itself to the most efficient and most beneficial care of these patients; and

The Committee *recommends* approval of the resolution as amended.

Adopted as amended by the House

The Reference Committee listened with attention and interest to Doctor Kenneth Gardner's remarks on the acute need for establishment of local psychiatric diagnostic centers to assist individuals toward the proper secondary treatment facilities available among the diversity of such agencies. He also pointed out that aid for this must come from local psychiatric communities and the appropriate State agencies both for personnel and finances. In response, the Committee felt that other reports and resolutions submitted move toward this end.



Dr. Rulon W. Rawson, Dean, New Jersey College of Medicine and Dentistry, accepting AMA-ERF check from President Kustrup.

Reference Committee "G"

Josiah C. McCracken, Jr., M.D., Chairman

Reference Committee "G" met on Sunday, 18 May 1969, with all members present: Doctors Charles L. Cunniff, William A. Dwyer, Jr., Edward Foord, Raymond A. McCormack, Jr., and the chairman. Approximately 24 delegates and members were present to discuss the various items under consideration.

1. **Public Health** (page 361)

There was considerable discussion especially concerning the paragraph on the "Guide for Hospital Perinatal Mortality Study Conferences" with special concern over the action of the Board of Trustees toward the subject; however the Reference Committee's discussion will be summarized in the report concerning Resolution #24.

The Reference Committee *recommends* approval of the report of the Council on Public Health.

Adopted

2. **Air Pollution Control** (page 362)

The Reference Committee commends the Committee on Air Pollution Control for its active participation and *recommends* that the report be approved as submitted.

Adopted

3. **Cancer Control** (page 363)

The Reference Committee *recommends* that the report be approved as submitted.

Adopted

4. **Child Health** (page 363)

Reference Committee "G" wishes to give special commendation to William J. Farley, M.D., the chairman of the Committee on Child Health, and the members of the committee, for long hours of service and the excellent standards and energetic aims of the committee.

The Reference Committee heard discussion of all aspects of the report, *recommends* approval, and wishes to make the following comment concerning Paragraph #5 on Sex Education:

The Reference Committee agrees wholeheartedly with the recommendation of the Committee on Child Health that the "Guidelines for Developing School Programs in Sex Education" compiled by the State Department of Education should be utilized by teachers because it promotes a sensible, balanced approach to this problem.

The paragraph concerning Perinatal Morbidity and Mortality (page 365) was discussed in conjunction with Resolution #24 and will be recorded later in this report.

Adopted

5. **Conservation of Vision** (page 366)

The Reference Committee *recommends* that the report of the Committee on the Conservation of Vision be approved as submitted, and further *recommends* that special emphasis be placed on the provision that the Eye Health Screening Programs for the general public be conducted only in hospitals, as well as the recommendation that the Board of Trustees continue to take whatever steps are necessary in the protection of the public to insure that only licensed medical practitioners and their legally authorized assistants be permitted to use drugs in eye examinations.

Foregoing paragraph amended by the House to read:

The Reference Committee recommends that the report of the Committee on Conservation of Vision be approved as submitted, and further recommends that the Board of Trustees continue to take whatever steps are necessary in the protection of the public to insure that only licensed medical

practitioners and their legally authorized assistants be permitted to use drugs in eye examinations, under the direction of physicians.

Adopted as amended by the House

6. **Maternal and Infant Welfare** (page 368)

The Reference Committee reviewed and discussed the report of the Committee on Maternal and Infant Welfare and *recommends* approval of the report as submitted.

Adopted

7. **Resolutions:**

a. **School Bus Safety** — Resolution #17 (page 398)

The Reference Committee was pleased with the interest in this resolution and *recommends* its approval with the following revision (indicated by italics) in the "RESOLVED" section of the resolution:

"RESOLVED, that The Medical Society of New Jersey give due consideration to said recommendations and take those steps, including instigation and pursuit of proper legislation, as necessary to implement *the principles* of said recommendations."

Adopted

b. **Standardized College Health Report Forms** — Resolution #20 (page 400)

The Reference Committee *recommends* approval of Resolution #20 (page 400)

Adopted

c. **Distribution of Perinatal Study Guide to Hospitals** — Resolution #24 (page 404)

There was considerable discussion and comment on Resolution #24. It was noted in the report of the Council on Public Health that "the Board of Trustees at its February meeting — disapproved the "Guide" ("The Guide for Hospital Perinatal Mortality Study Conferences") as being too detailed and impractical of implementation." In the discussion in the reference committee meeting, it was reported by a member of the Board that the Board of Trustees did not disapprove of the principle of such a guide. Therefore, Reference Committee "G" *recommends* that Resolution #24 be approved by amending the "RESOLVED" (indicated by italics):

"RESOLVED, that The Medical Society of New Jersey distribute and strongly recommend to all hospitals in New Jersey the use in whole or in part of the "Suggested Guide for the Hospital Perinatal Study Conference."

Tabled



Reception for President-Elect Bertha.

Reference Committee "H"

Roy A. Morrow, M.D., Chairman

Reference Committee "H" met on Sunday, 18 May 1969, with all members present: Doctors Winton H. Johnston, George J. Kohut, Frank W. Konzelmann. I. Edward Ornaf, and the chairman. Approximately 5 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

a. **Relief of Widows and Orphans of Medical men** (supplemental #2, page 313)

Reference Committee "H" discussed the continued need in this area in spite of our prevailing "affluent society" and noted the threefold increase of the death benefits over an eight year period of time. Although membership is at a new high, the desirability of encouraging new and young physicians to join the Society was agreed upon.

The Committee commends the officers of the Society for their dedicated services.

The Committee *recommends* approval of this item.

Adopted

b. **Revision of FAA Medical Examination Form for Pilot Certification** (page 310)

The Committee suggests a follow up to insure passage of the required legislation to render physicians immune from suits for reporting disqualifying conditions in airmen to the FAA. The Committee *recommends* approval of this report.

Adopted

2. **Annual Meeting** (page 320)

The bulk of the discussion on this report centered around the problem of the decreasing attendance of physicians and exhibitors at our annual meetings, and the quality and composition of the scientific sessions. A suggestion was made to have separate Legislative and Scientific meetings. A proposal was made to encourage the specialty groups throughout the State, to combine all their separate annual meetings at one time under the aegis of the Scientific Session of The Medical Society of New Jersey, and for each specialty to formulate its program to stimulate maximum attendance by its membership.

The Committee suggests that the aforementioned be referred by the House to the Board of Trustees.

The Committee *recommends* approval of this report.

Adopted

3. **Honorary Membership** (page 323)

The Committee *recommends* approval of this report.

Adopted

4. **Woman's Auxiliary Advisory** (page 341)

The Committee *recommends* approval of this report.

Adopted

5. **Nominations for Emeritus Membership** (page 385) and supplemental (page 385)

The Committee *recommends* approval of this report.

Adopted

The chairman thanked the physicians who participated in the discussion and Committee members for their support and assistance in formulating this report.

Reference Committee On Constitution And Bylaws

Karl T. Franzoni, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Sunday, 18 May 1969, with all members present: Doctors Harry R. Brindle, Irving R. Hayman, Peter H. Marvel, Adolph R. Wichman, and the chairman. Approximately 10 delegates and members were present to discuss the various items under consideration.

1. **Revision of Constitution and Bylaws** (page 339)

The Reference Committee *recommends* approval of the recommendations of the Standing Committee on Revision of Constitution and Bylaws with regard to the following resolutions not adopted by but referred for consideration by that Committee as a result of actions taken by the 1968 House of Delegates.

a. **Resolution #26 — Constitutional Amendment to Effect More Proportionate Representation on the Board of Trustees**

That a mortatorium of at least three years prevail to ascertain the effectiveness and adequacy of the new constitutional provision on this matter.

Tabled

b. **Resolution #27 — Establishment of an Ad Hoc Committee to Redistrict the State to Provide Proportionate Representation on the Board of Trustees**

That no action be taken in this area at the present time because the recently adopted constitutional amendment (1968) has not been in existence long enough to support proper evaluation.

Adopted

c. **Resolution #35 — Osteopathy**

The Reference Committee agrees that any constitutional provisions providing for the assimilation of doctors of osteopathy into The Medical Society of New Jersey must be preceded by an affirmative decision rendered by the House of Delegates. In the latter circumstance, the Standing Committee on Constitution and Bylaws would prepare an appropriate amendment for presentation at the next annual meeting.

Adopted

2. **Classification of Membership**

The reference Committee approves the policy that any constitutional alteration in this regard must similarly depend upon a major policy determination by the House of Delegates. (page 340)

Adopted

3. **Revision of Bylaws Pertaining to Citizenship Requirements**

The Reference Committee *recommends* the approval of the proposed change in the Bylaws relevant to qualifications of members as submitted by the Standing Committee on Constitution and Bylaws (page 340).

Adopted

The Reference Committee would like to compliment and commend the Standing Committee on Constitution and Bylaws for its diligent work throughout the year.

Report of Nominating Committee and Election—May 18, 1969

Louis K. Collins, M.D., Chairman

OFFICE	TERM	NOMINEE
President-Elect	1 year	Emanuel M. Satulsky, M.D., Wharton
1st Vice-President	1 year	E. Vernon Davis, M.D., Moorestown
2nd Vice-President	1 year†	Richard R. Chamberlain, M.D., Maplewood
Secretary	1 year	Charles L. Cunniff, M.D., Jersey City
Treasurer	1 year	Samuel J. Lloyd, M.D., Trenton
Trustees:		
1st District	3 years	Edward G. Bourns, M.D., Westfield
	3 years	Robert Anderson, M.D., Newark
2nd District	3 years	Matthew E. Boylan, M.D., Jersey City
	3 years	James A. Rogers, M.D., Paterson
3rd District	3 years	George E. Barbour, M.D., Somerville
	3 years	David Eckstein, M.D., Trenton
4th District	3 years	I. Edward Ornaf, M.D., Camden
Judicial Councilors:		
1st District	3 years	Thomas S. P. Fitch, M.D., Plainfield
4th District	3 years	Frederick W. Durham, M.D., Haddonfield
AMA Delegates:	2 years	Joseph P. Donnelly, M.D., Jersey City
	2 years	Jesse McCall, M.D., Newton
	2 years	Isaac N. Patterson, M.D., Westville
AMA Alternate Delegates:	2 years	Joseph R. Jehl, M.D., Clifton
	2 years	Robert E. Verdon, M.D., Cliffside Park
	2 years	Emanuel M. Satulsky, M.D., Elizabeth
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Trenton
Alternate	1 year	Josiah C. McCracken, Jr., M.D., Ventnor
Connecticut:		
Delegate	1 year	Lloyd A. Hamilton, M.D., Lambertville
Alternate	1 year	Peter H. Marvel, M.D., Northfield
Administrative Councils:		
Legislation:		
5th District	3 years	John S. Madara, M.D., Salem
6th Member	3 years	Winton H. Johnson, M.D., Hackensack
Medical Services:		
5th District	3 years	David R. Brewer, Jr., M.D., Woodbury
6th Member	3 years	David Flinker, M.D.,
Mental Health:		
3rd District	3 years	Robert S. Garber, M.D., Belle Mead
6th Member	3 years	Evelyn P. Ivey, M.D., Farmingdale
Public Health:		
1st District	2 years**	George L. Erdman, M.D., Summit
3rd District	1 year*	Thomas F. McLaughlin, M.D., Metuchen
5th District	3 years	Robert G. Salasin, M.D., Wildwood
6th Member	3 years	Francis E. Rieman, M.D., Jersey City
Public Relations:		
2nd District	3 years	Francis I. Tomlins, M.D., Ridgewood
5th District	3 years	Josiah C. McCracken, Jr., M.D., Ventnor
Standing Committees:		
Annual Meeting	3 years	Robert E. Verdon, M.D., Cliffside Park
Finance and Budget	3 years	Louis G. McAfoos, Jr., M.D., Cherry Hill
Medical Defense and Insurance	3 years	Paul J. Kreutz, M.D., Elizabeth
Medical Education	3 years	Edward H. Weiser, M.D., Sussex
Publication	3 years	George B. Sharbaugh, M.D., Trenton
Woman's Auxiliary Advisory	3 years	William J. Roe, M.D., Englewood

* Elected to fill unexpired term

† William J. D'Elio, M.D. of Monmouth County (Neptune City) was nominated from the floor—and elected by the House—as 2nd Vice President

** George L. Erdmon, M.D., of Union County was nominated from the floor—and elected by the House—to fill the unexpired term (1st District) of Edward G. Bourns, M.D., who resigned in view of his election to membership on the Board of Trustees

Adopted as amended by the House

GENERAL SESSION

Sunday Afternoon, May 18, 1969

The General Session was convened at 4:00 p.m., John F. Kustrup, M.D., President, presiding.

Dr. Kustrup: We will now call the General Session to order. Will you please be seated?

At the termination of Dr. McCorkle's presentation we will have a question and answer period. We will distribute cards which will be picked up and answered after they are received at the head table.

We will now open the General Session of The Medical Society of New Jersey. We are privileged to hear from Lloyd W. McCorkle, Ph.D., Commissioner of the New Jersey Department of Institutions and Agencies. His subject is the New Jersey Medicaid Program. Dr. McCorkle.

(Applause)

Dr. Lloyd W. McCorkle: Mr. President, Delegates and Friends of the Department of Institutions and Agencies: I was thinking, when Dr. Kustrup was trying to get everybody to order, of an experience that occurred to me when I was a graduate student at the University of Chicago. I was there when war was declared. If you recall, the President of the University of Chicago at that time was Dr. Hutchins and he was not for involvement in the war; in fact I think he was opposed. So everybody was quite anxious to find out what Dr. Hutchins was going to say.

Right after the Japanese struck at Pearl Harbor the University of Chicago was on a quarter system. It went on vacation and President Hutchins did not have anything to say until after the first of the year, and he decided that he would make a public statement in Mendel Hall at the University after the first of the year. Everybody gathered. There were so many students but there were so many newsmen and so on present that there was not too much room for the students, but some got into the hall, and, for whatever reason, the girls tended to congregate to the left and the boys to the right in the hall. So we waited and waited and finally President Hutchins showed up. And instead of coming forward to speak, he just took a seat. He stayed there and things were very quiet. Everybody waited and about five or ten minutes went by and finally the girls started to push their feet back and forth on the floor. This noise picked up and up and then the boys started to do it. And finally President Hutchins got up. He walked over. He looked out over the group and everybody, of course, was still shuffling their feet, and he said: "When the foolish virgins and their male counterparts cease, I will begin." So now I can begin to talk about Title 19.

I was pleased to come down here to talk to you a bit about Title 19. In fact I rather suspect that Dr. Hughes, who has been so active both in your Society and so influential in the affairs of our Department, may in measure be responsible for my being here because he and I have talked many times about how your Society and our Department is going to have to collaborate to make the Title 19 program in New Jersey work. It is important to you as an influential group of professionals that this work receives as little criticism as possible, and that it receives broad acceptance and support. Needless to say, for the State Board of Control — of which Dr. Hughes is a member and of which I am the chief executive officer — it is very important that it function, and that it function well, that it promote confidence, and that we have the kind of program that you want and which our Department wants under this important amendment.

Now, to do this, this Society is going to be very, very important. We are going to need your collaboration in the months immediately ahead and very importantly after January 1970. We are going to need to work together. You are going to have to help us in our recruitment drives to get physicians in local

communities to function with us to control this program. If you don't, we can end up in the soup as it were. So it's with that kind of thought in mind that it was, in one measure, almost politic to get down here to talk to you today.

Now, the Title 19 Medical Aid Program or Medical Assistance is a grant-in-aid program in which the federal government offers to share with state governments on a varied percentage basis — fifty per cent in New Jersey, more elsewhere, not less anywhere else — the cost of high quality medical care for people with no income or low income. The ultimate goal expressed in federal law is that by 1975 these health care services will be readily available to all persons unable to pay for them. New Jersey must, between 1970 and 1975, barring changes in the legislation, escalate its program upward to include all these groups.

In the original interpretation Congressional intent was to do away with the welfare stigma in the provision and payment for medical service and to eliminate any suggestion of a two-class system of health care. The federal government placed no limitation initially on the scope of the services or funds expended by a state in meeting program goals. States were encouraged to establish high standards to insure quality care, to develop procedures and policies to achieve the standards, and to make appropriate arrangements to help eligible persons get the care and services needed. The state agency and its local units were encouraged to provide social services to help people recognize the need for medical care, to establish procedures to assure that needed and essential care is readily available and accessible, to foster continuity of care, and to assist persons in the resolution of social problems related to medical conditions.

The state administrative agency is responsible to establish or to arrange for the use of fiscal agents whereby payments for authorized care and services furnished to eligible persons are promptly approved and made to the providers of service.

Due to the rapid escalation in the cost of health care over the past few years and the excessive expenditures over estimates in many states especially in New York, more recently in New Mexico, Maryland, Oklahoma and Tennessee, Congress has placed a ceiling on the financial eligibility standards in order to limit federal participation.

The mark-up value required by New York State to meet this change in the federal law is well known and has been dramatically headlined in the newspapers during the past year. New York State, adjacent to us, has had a great deal, first of criticism, then of other problems, finally a cut-back, and again the inevitable criticism of people who felt they were phased out of the program.

The New Jersey program, which will start in January 1970 and to which I want to refer in just a moment to try to bring you up to date—at least tell you as much as I know—is referred to and has been referred to as a mini-medicaid program. However, it is comprehensive and offers a broad scope of services. Our Department insisted on this and it got written into the law. But the mini character comes in the restricted segment of the needy population eligible.

Essentially the New Jersey program is limited to those persons receiving public assistance through the county welfare boards, persons eligible to receive this assistance if they applied for it, and children in foster care. These are the categories covered by the New Jersey program.

It does not, however, cover persons receiving financial assistance from municipal departments of welfare. It does not cover families with handicapped children whose income exceeds public assistance standards but who have major medical expenditures which could very well pauperize the family. Many other examples of limited coverage could be cited but they need not be enumerated to a group of physicians.

The Department of Institutions and Agencies

is aware of the position of The Medical Society of New Jersey relative to usual and customary fees. However, there has been no decision that the New Jersey Medicaid Program will be paying providers on this basis.

It is increasingly apparent that the federal government may not approve a fee structure based on payment to providers of usual and customary charges since there are indications of intent to limit drastically the federal expenditures for Medicaid. Although the states have not received federal guidelines relating to limitations on provider reimbursement schedules our information, mostly derived by reading the same publications available to all of you, indicates that we may very well anticipate some type of fixed fee schedule mandated by the federal government.

The Division of Medical Assistance and Health Services, created by the New Jersey Legislature and established by the State Board of Control to administer the Medicaid Program, will make use of a medical advisory committee and a number of technical advisory committees covering the various health services specified under the scope of the program.

We welcome the expertise available from the various disciplines or specialities within medicine and the allied health professions and will be seeking within the very near future the assistance of all specialty groups to assist our planning staff. We are working on draft material which will be presented to the various technical advisory committees for their consideration and comment. We do not plan to come up with an operating program established by a few bureaucrats. We need and will seek the advice and counsel of the Medical Society, not just in relation to fee structure, but we are going to seek your advice and counsel in order that the total program may be realistic in purpose and process, which to some extent I would submit to you is the most important thing both from your Society's point of view and our point of view as administrators of the program.

Utilization, both under-use and over-use, is of great concern in the operation and administration of a program which will, within the next few years, be spending hundreds of millions of taxpayers' funds in New Jersey. These are your funds and my funds, and you and I have an interest and concern in how this money is spent.

We need your help and counsel, for instance, on the appropriateness of a single provider of non-surgical medical care receiving over $500,000 in an 18-month period under the Medicare Program. This occurred. Is this reasonable?

We have been asked this week, for instance — by the way, the instance cited by the federal government about the person involved happens to be from New Jersey. We have this week been asked to look into the case of a physician who has billed for his welfare patients alone, based on a $5.00 per visit fee, $7,000 for services rendered during a three-week period. A quick mathematical calculation reveals that this physician must render a service to 70 welfare recipients daily, seven days a week, and this physician's practice is by no means limited to welfare recipients.

Guidance was sought from the county medical society, I presume the judicial committee, by our Department. But neither the welfare director of the county nor his medical consultant, who incidentally was a past-president of the county medical society, received any constructive help.

When fraud is discovered, such as duplicate billing, the help of the local medical society is not required. In such instances the responsible agency uses the legal department.

I would certainly make a plea that the Medical Society, if it is to play a meaningful role in the on-going operation of the Medicaid Program, give careful consideration to the establishment of utilization review committees in each county or restructuring the judicial committee of each local society to handle all questionable practices referred by the local medical assistance units. The peer review thus

afforded would be of invaluable assistance in the administration of the Medicaid Program. I say this because New Jersey will have the same problems as encountered in all the other states and we would certainly prefer that the county medical society or the State Society handles the problem, good or bad, which will arise when the programs become operative. We want to involve the local medical societies and the State Society. Here is where we believe the review should take place — not ignored there and then ultimately have somebody in Trenton doing it. I think you and I both recognize that this would be a most undesirable way to resolve the problems.

The Department will establish and hopefully maintain open channels of communication with the organized professional societies. This should be a two-way street and hopefully no credibility gap will arise in either direction. Other states have proven that the program has problems. We believe it can also have promise if this is a goal we share together.

Thank you very much. Thank you, Mr. President.

(Applause)

Dr. Kustrup: Thank you, Dr. McCorkle.

Now, I'm sure there are questions about Medicaid. If you will pass them up to the front, we'll have Dr. McCorkle answer them for you.

While we are collecting the cards, I'm certain that everyone here agrees with me that the Medical Society, both local, on the county basis, and on the State basis, is not anxious to protect anyone who is abusing Medicare or Medicaid in any way. If the carrier would protest officially about the actions of such physicians, they will be placed before the Judicial Committee and acted upon in the proper manner.

Dr. McCorkle: I have a number of questions here. Who are the members of the Board of Control? How did they get there? And how long have they been there?

New Jersey has a very interesting statute. It was passed and signed into law in 1918. It established the Board of Control and it states, among other things, that the State Board of Control is the supreme and final authority. This always comes as something of a surprise to theologians. But that's what the law states.

The State Board of Control consists of nine members who serve terms of eight years; one leaves each year. And by the way, The Medical Society of New Jersey has always had a member on the State Board of Control since the inception of the Department in 1918. Your present Society member — well, you have many Society members involved in our Department, but the Society member who is on the State Board of Control is Dr. Hughes, who has been on the State Board of Control I would estimate, calculating quickly, about twelve years. I'm right. And when you get that from the supreme and final authority you don't have to worry anymore.

The President of the State Board of Control is Mr. Lloyd Wescott who is active in a whole range of welfare, health, and charitable affairs. He is a dairy farmer in Hunterdon County and is widely respected throughout the United States for his contributions to agriculture, the dairy industry, and also for his recognized eminence as a voluntary citizen in the area of health and welfare.

The Board generally, I would say, represents a broad cross-section of public opinion in New Jersey. I happen to be the chief executive officer of the Board — am appointed by the Board with the approval of the Governor. The Board is appointed with the advice and approval of the Senate.

How did they get there? I'm afraid the person who asked that will have to ask Dr. Hughes. I'm not on it and I don't know the process on how you get there.

Is it foreseen that there will ever be need for on-site scrutiny of the records of physicians, as has been true in New York under Medicaid?

I don't know. I can't predict the future. I would hope not. I would hope that Dr. Bernstein and Dr. Kaplan will be going to all the local medical societies trying to recruit. And we recognize that we have problems with salaries and what we can pay people, but I think to some extent you are going to have to see some of this not so much in terms of what the salary schedules in the State are, and they are admittedly inadequate as far as I'm concerned, particularly as it relates to unique professional skills like medicine, but you are going to have to look at it in terms of a joint responsibility to keep this program so that it is a reflection of a cooperative spirit between your State Society, the local societies, the Department of Institutions and Agencies, and the local welfare boards. They are going to be going to the local societies recruiting area consultants and we would hope that by this method we will have the kind of review that will enable us to give the kind of general acceptance and assurance that will make the kind of detective work that is implied in this question unnecessary — certainly hopefully so.

What is the estimated total of patients to be covered in New Jersey under Medicaid?

In excess of about 350,000. That's what we are talking about.

Since membership in the county medical society is not necessary in this State, how do you propose that the Medical Society discipline fraud in Medicare or Medicaid?

I don't think that you are called upon and the Department is not called upon to discipline people about fraud. This is a matter for the county prosecutor. When there is fraud, you have a violation of the statutes. I think anybody who would be fraudulent under Medicaid or Medicare ought to have his head examined. It's a matter of definitions that deal with utilization that create many of the problems. And here you are not dealing in the area of criminal statutes; here you are dealing with the kind of discipline that can only be exercised by peers, by professionals who know, and by professionals speaking to one another, talking to one another and reviewing what one another is doing.

Why do we, the medical profession, strive to make something work that we do not believe in?

It was my understanding that the Title 19 program by and large was a Congressional expression, perhaps not of what was originally intended, but a Congressional expression of a proposal from the AMA around Eldercare. Now, whatever may be your individual or group or organizational problems, the fact remains that I personally believe, and I think most of you believe, that when individuals receive service, the State has some responsibility to pay the provider of the service. This is going to happen in New Jersey after January 1, 1970. The important thing about it is for us to make it work in a way that it will be accepted and broadly supported by the people of the State. Whether you believe in every aspect or every nuance of the program or not, it seems to me from personal and organizational points of view, just as from my personal and organizational point of view, irrespective of what my personal convictions may be, it is important that we have a workable program that will not result in the kinds of controls and interference, which appropriately the Medical Society views with a jaundiced eye. They don't have to be necessary.

I think we can operate this program. Sure, there will be some things we may raise some questions about. But if on the whole we work together, if we mutually explore problems together, I think the program can work in a way that we can maintain a dignified professional relationship between the provider of the service, the agencies involved, and the recipient of the service.

This is going to be a crucial test and I think, although this was perhaps only implied in the question, it's going to have times when it's going to test — test individuals, test local groups, test relationships. But I think the relationship that has existed between this Society and our Department over these many

years, with the close liaison that exists between your societies at the local level and our Department — because many members of the societies serve on various boards throughout the Department — and New Jersey's long tradition of relationships between voluntary groups and the administration of programs particularly in our program, could very well make our State a model. We could do here what New York couldn't do, what New Mexico couldn't do, what Tennessee couldn't do, what Oklahoma didn't do, chiefly because we have this reservoir of past experience working together going in our favor, at least that is my hope.

How does the federal government promise "highest quality medical care" with low quality fees!

In the legislation it does say high quality medical care and you and I both know that you can in the United States offer high quality medical care because it's here. It's here in a State like New Jersey. It is practically everywhere in the State of New Jersey. There may be a few isolated places throughout the United States, but happily I doubt if there are many in this State of New Jersey. So it can be promised.

Now, low quality fees. We don't know what the fees are going to be. I don't know what it's going to be. It may very well be exactly what you say it ought to be — usual and customary.

Let me pause then for a moment here and break into the New Jersey program. As you know, the New Jersey legislation, admitted by the people who wrote the bill, is an interesting kind of compromise bill. They put both sides of the controversy into the legislation and everybody walked out, I suspect to some extent thinking they were going to get what they wanted. The Assembly was interested in an underwritten program. The Senate did not wish an underwritten program. I suspect if they had a preference it was for a fiscal intermediary. So both got written into the law.

If you read your papers you know that it was decided that the State of New Jersey — the Medicaid Commission — set up a Medical Commission in this law that includes the President of the Senate, the Speaker of the Assembly, the Governor, and the Commissioner of the Department of Institutions and Agencies.

The Commissioner of Institutions and Agencies is in a rather interesting position with reference to this since the law requires that he makes recommendations to the other members of the Commission.

Although I wrote to the Attorney General for an interpretation of the statute — I might add I have not received it yet and I am not at all surprised at that because it is a very confusing piece of legislation. But we decided that we had to go out first for an underwritten program. One came in. It was written by Blue Cross-Blue Shield. Since there was only one bidder, there was nothing to compare with really, and since actually in terms of underwriting it's kind of a myth since every six months you have a review and if the person who received the bid had a deficit, you make it up. And if he had a surplus, this presumably went into a special revolving fund to be utilized in connection with the Medicaid Program. The Medicaid Commission rejected it.

Then the law requires us to go out for a bid from a fiscal agent. Again it is difficult to understand because if there is a deficit the State will pick up the deficit, and if there is a profit presumably that will be taken care of in the adjustment of the fees in the future because it's non-profit.

Two bids were received, one from Prudential, one from the Blues. There was also a bid on the dental care by another group.

But as you look at the estimates for administrative costs you can only come to one conclusion. Either the Blues are the most efficient group in the world and PRU the most inefficient or something, because there is a difference of 45 cents in the cost for processing

the claim. This relates to an estimate of one carrier around the number of personnel as compared to the other carrier. There is a difference, I think, of about 255 people.

The Medicaid Commission was to meet last Thursday to resolve this issue, presumably, and make some determinations. They did not meet because of the problems involved in the analysis of the two bids. But to some extent the whole thing becomes just a bit irrelevant because, as I pointed out, if I run a deficit the State has to pick it up; if there is a surplus it will be returned to the State.

I don't know how this thing is going to work itself out. The analysis is being conducted by the Division of Medical Assistance and Health Services. Mr. Hahn, Mr. Poinsett, Drs. Bernstein and Kaplan are working on this matter and we've got to resolve the problem soon because of the limited time available to get tooled up for the program.

Will the Medicaid contract be given to the responsible company which submits the lowest bid? If not, why? What was the purpose of the bids?

I think I have answered that. The purpose of the bids primarily is to conform with the legislation. And I am not being critical here, I think actually your representatives in the Legislature were expressing many, many anxieties about the program. They had before them the sorry experience in New York. They did not have equally before them the promise that is possible in this program from some other states. They tried to build in a whole variety of controls. The Department's proposal I think was the most sensible one. The Department's proposal was that the Department of Institutions and Agencies be responsible for administering the program and the Department be given the authority to negotiate with fiscal intermediaries for those parts of the program which the Department determined could best be handled by this method. But this gave a range of administrative discretion that I quite frankly think the Legislature was extremely concerned about and so instead of using the Board of Control, they ended up using a Medicaid Commission. And instead of giving it the flexibility, they wrote in the law all this stuff around bidding.

There is a question here about what services — actually there are two of them. What services are you paying for?

The New Jersey program has all services with the exception, I think, of home health visits by nurses. All 13 services — in-patient, outpatient, dental, prosthesis, emergency, x-ray, diagnostic, these are all in the New Jersey program. Our program is extremely comprehensive. It doesn't put a duration on illness. It makes reasonable and fair assumptions in terms of the comprehensive character of services to be provided. As I indicated to you, the criticism that has been leveled at the New Jersey program is that it is restricted to such a limited number of persons.

Has it been determined who will be the fiscal intermediary?

I've just answered that. It has not.

When or on what basis will the fiscal intermediary be appointed?

He will be appointed by the Medicaid Commission, and, having been appointed by the Medicaid Commission, he will then work out a contract with the Department of Institutions and Agencies. He will pay the providers. We will pay him so much for handling each claim.

Have you designated the Medical Advisory Council members?

The structure of the Advisory Committees has been discussed by the State Board of Control. I think they are reasonably certain as to how they are going to proceed. They have lists of names that have been provided from a variety of sources, one for the large committee that will be, in a sense, a representation of professional groups, plus consumers of service, and then the technical advisory committees which will assist them.

Have they been designated by name? To the best of my knowledge, the information has not gone out inviting people to serve. The reason for this is we have to get this basic question settled prior to calling them in. We would be in the position of calling them in, they would ask us what kind of a program they are to give advice on and we would be unable to tell them.

I would think that we will start having committee meetings. And the time involved, from the point of view of some of these people, may be exorbitant but it is, again, I repeat, not our fault. We will start, I would assume, the latter part of this month with accelerated meetings in June so that we can get this program ready for a dry run in September. We have to have that, otherwise we are going to be in a real chaotic condition come January 1.

Would I explain children in foster care?

These are children who are the responsibility of the Bureau of Childrens Services. They are children for whom, for whatever reasons, courts have determined that the Bureau of Childrens Services will provide services, make arrangements for them either in foster homes, residential care, or wherever, because the parents are unable, unwilling, or what have you to do this for the child.

The recipients in 1970 I have defined. They are all those persons who are receiving assistance under one of the federal categorical programs from the local county welfare board, or persons who if they applied for assistance would receive assistance. And they do not include the groups that I indicated. If they are on municipal assistance, they are not eligible. If they are persons with low income but would not be eligible for a federal categorical program, that's too bad. They are not in the program because New Jersey does not have a group for medically indigent. You will have by 1975 unless the law is changed.

How many people are eligible?

I did answer that. In the neighborhood of 350,000 to 400,000.

Well, the next question is: Is there contemplated a medically indigent group?

The State Board of Control and the Department argued that there should be. We proposed what we thought was a reasonable definition for medical indigency. If you recall, the Commission headed by then Assemblymen Tansman and Bateman that studied health care costs supported the position of the State Board of Control and the Department. We said that people should be considered medically indigent if during a three-month period of time their medical bills were such that they would become eligible for public assistance.

The next question is like the first one. Is there inconsistency in the government asking for high quality care and then wanting to give people less than their usual and customary fees?

I think there is some inconsistency. I think that on the other hand unless groups such as this and the people who administer these programs work out ways to effect the kind of discipline that gives you and me as taxpayers assurance that the buck is being wisely and well spent, then you inevitably run into this problem of how are you going to exercise controls. And I think admittedly we are talking about — you know, we are talking about a handful of individuals. But I am in a department where I am constantly under pressure because of the idiosyncratic and the unusual and I get no credit for the normal and the routine and I think this is where you and I need to think of ways to cement our relationship, to collaborate and to make certain that you and the public administrators can defend and get general acceptance and support for the program.

The next question is: You mentioned a physician who received $7,000 in three weeks. Are you at liberty to state whether this individual was an M.D. or otherwise?

I'm not at liberty. I don't know. But if you ask Dr. Bernstein I'm sure he will identify him for you. In connection with this paper I

was discussing this case that was given to the people in the Division of Medical Assistance, to know what, from their point of view, would be a point that I could emphasize that would be most helpful in the future administration of this program. This case and the other one with the $500,000 happened to be mentioned and I thought despite the fact they were rare and unusual they would forcibly bring home the kind of crucial and central issue that you and I are confronted with.

I think I have answered all the questions. And again, Mr. President, let me thank you for having me here.

(Applause)

Dr. Kustrup: Thank you very much. We are most grateful for having the Commissioner here and I think he answered questions as ably as anyone could, as forthrightly as possible, and we appreciate everything he has done and is doing.

(Applause)

MEDICAL-SURGICAL PLAN

Saturday, May 17, 1969

Joseph P. Donnelly, M.D., President of Medical-Surgical Plan of New Jersey, presided. The discussion convened at 4:25 p.m.

Dr. Joseph Donnelly: Gentlemen, I know the hour is late and you have had a long session, but any of those who are really interested in this if you will please come up a little forward, we might do a little better.

I only have a few remarks to make. I'm going to touch very briefly on some of the highlights of the past year in Medical-Surgical Plan. First, since we are in the final year of the 1960's it might give us a little perspective to take a quick look back from 1958 to 1968. During that time we've had two rate increases — in 1961 and 1967 — which add up to a total average increase of 27.9 per cent. This is almost identical with the increase in the overall cost of living during that time, which went up 27.8 per cent.

Even with the fee increases that have been made over the past 10 years, we know that the Blue Shield Fee Schedule doesn't come up to the usual charges of today. But I think the big point we have to consider here is how this relates to the Service Benefits subscriber of today — the family with an income that is under $7500 and who on an average has 2.2 children. Due to inflation, the purchasing power of a $7500 income in 1958 has shrunk to $5400 today. On this basis, I believe the Fee Schedule is a reasonable one, particularly when you take into account the fact that only 40 per cent of our subscribers today have incomes low enough to qualify for Service Benefits. For the remainder, of course, a Participating Physician can collect the balance of his usual fee from the patient.

Here are some other quick comparisons between 1958 and 1968:

Our membership has grown from 1.8 million to over 3 million, an increase of two-thirds. Claims incurred went up from $25 million to over $58 million — more than double. The number of services paid for increased from 400,000 to more than 1.2 million — just about triple.

In 1958 there were 6,959 eligible practitioners — M.D.'s and D.O.'s — in New Jersey. Last

year, the number of eligible practitioners — who now include Podiatrists, Dentists, and Bioanalytical Laboratory Directors — was 9,188. This is an increase in practitioners of only 32 per cent, while benefits paid by the Plan have increased by 132 per cent.

And here is an interesting fact about the type of services paid for. This is something that comes up frequently. We used to hear that we should drop the word "medical" from the Plan's name, because it was really a surgeon's plan. Well back in 1958 medical services represented 17.5 per cent and surgical services 43.3 per cent of all the services paid for by the Plan. In 1968 medical services represented 40 per cent of all the services paid for and surgical services were just a shade higher, at 40.9 per cent. I don't think anyone can say today that Blue Shield is surgically-oriented or surgeon-dominated. On our Board of Trustees we have six internists, four surgeons, one obstetrician, two general practitioners, a pathologist, a pediatrician, an anesthesiologist, and a radiologist, plus a college professor, two hospital administrators, four businessmen, a retired editor and a retired businessman. We are submitting for The Medical Society's approval this year the names of an eminent attorney and an outstanding labor leader, both of whom have been good friends of Blue Shield.

Now a few quick comparisons between last year and 1967:

Our membership growth in the last year went over 188,000 and was the greatest in the past ten years. Claims incurred hit a new high of $58.5 million up $5.5 million over 1967. Our financial condition remained sound, with a slight gain in reserves. The number of Participating Physicians reached an all-time high, but still leaves a good deal to be desired in two specialty fields.

Rider J coverage showed an impressive gain, being added by 255,000 members. Over 1.3 million persons now hold this coverage for services in the doctor's office, hospital outpatient department or registered laboratory. Similar coverage for services in the doctor's office was introduced for Medicare beneficiaries holding the "Blue Cross and Blue Shield 65" complementary program, via Rider 65, which received wide acceptance.

The Plan is encouraging physicians to use a new billing procedure which should eliminate problems over Service benefits and income. This was described in a recent advertisement in The Medical Society JOURNAL, and reprints are available at the Blue Shield booth in the Exhibit Hall.

The Prevailing Fee program is well off the ground, and we expect it to become the dominant Blue Shield program in the future. We commend participating in this program, which pays usual, customary and reasonable fees, to those physicians who have not yet signed up for it, and particularly call it to the attention of our Participating Physicians under the basic program who do not as yet participate under the Prevailing Fee program.

We are in the process of gathering data to present to the new Commissioner of Banking and Insurance in the hope of convincing him that Participating Physicians should be released from their "payment in full" agreement in cases where third-party liability exists. This is in the case of taking care of the injured in automobile accidents and so forth where the insurance company normally pays the physician's fees and in these cases we think this is not a Plan liability and we don't think the physician should be held to his agreement. This has been a sore point with both the profession and the Plan, and hopefully we may arrive at a more equitable solution with the new Commissioner.

We are making every effort to improve service — service in faster payment of claims, and service on your inquiries to our Physicians Inquiry Unit. We have been in a tight labor market, and it is a problem to keep all of our operations staffed up to their full needs. But we are beginning to see some daylight not the least of which comes from a more sophisticated and flexible computer system for processing claims, which we hope to put into operation almost any day now. We have also

just in the last week signed a three-year labor contract with our employees, so we foresee no labor difficulties in the near future.

Before closing, let me state that during the past year the members of the Board of Trustees, Doctor Rothgesser, Jim Zotti of the Physician Relations Section, and myself have made continual efforts to better communications between the doctors, many of the physicians' societies and the Blue Shield Plan. We attended the Annual Meeting of the General Practitioners, meetings of many of the specialty societies and also have met frequently with committees from the specialty societies and other interested groups in regard to Blue Shield policies. We realize that the strength of the Medical-Surgical Plan is directly proportional to the interest in it by the members of The Medical Society of New Jersey. We welcome your suggestions and constructive criticism and we urge you during the coming year to communicate to the Staff, the Trustees and the Officers of your Plan. We have a full staff downstairs in the booth for the next three days, which includes physician members and physicians' representatives. If you have any criticism, if you have any questions, please go down there and I assure you that we will make every effort to get these things straightened out.

At the end of my first year in office I wish to close on a personal note and to personally thank all of you for your interest and support by which you have made the Blue Shield Medical-Surgical Plan of New Jersey truly a doctors' Plan.

I don't want to preempt any more of your time — this is your meeting — so the floor is now open for your questions and comments. Are there any questions?

As I came up that aisle before, I would say that there were at least six people with questions who thought I was trying to duck them, and I kept on coming up here to get this meeting started. But we'll be around during the whole convention. Our booth downstairs is well staffed. And, please, if you have any suggestions, any criticism, or anything to urge us to do, please let us know before we go home.

Dr. Lloyd: Dr. Donnelly, Mr. President of the Blue Shield Plan, this meeting has been held annually in this manner for the past number of years, and sometimes it has been important to hold it. The last few years we find here a corporal's guard and many of the people who are either employees of the Plan or directly involved with the Plan as Trustees, and I wonder should we continue to ask The Medical Society of New Jersey to hold this meeting. It certainly gives everyone a chance to ventilate.

Apparently your communications throughout the year have been adequate to the point where we find no questions from the floor. And for the benefit of the Convention Manager and the people who will have the problem of planning for this meeting or skipping it next year, I think we ought to have an expression from the floor as to whether those who are here — these are the people who are interested, of course — would like to have another meeting next year like this. Or should we consider that the Blue Shield Plan is now mature enough, we understand it well enough that these meetings are no longer necessary.

Dr. Donnelly: Well, I would be inclined to agree with you, Dr. Lloyd, on what has happened both last year and this year. Of course, there will be a full discussion on some of the problems of Blue Shield and the whole thing in Reference Committee "C" tomorrow.

And certainly as far as I'm concerned, we want you to know that we are available, but I also know how tight the schedule is at this convention and I certainly think that the Board of Trustees, as far as the Blue Shield Plan is concerned, if there is no longer any need for this, would certainly be agreeable to have it cancelled.

If there are no further questions, then we'll adjourn the meeting. Thank you very much, those who did come.

DINNER DANCE

Monday Evening, May 19, 1969

Mr. Richard I. Nevin was Toastmaster.

The Toastmaster: Ladies and gentlemen, will you please rise for the grace before meals?

(Grace before meals)

The Toastmaster: Having called upon God, ladies and gentlemen, it is now my pleasure to call upon the Governor. Governor Hughes has hastened down here to be present briefly with us, and to accommodate him we have agreed at this time to present him to you so that he may say a few words. I don't know when the man eats, but I think that out of our concern for health in general we'll put a CARE package in his car. Governor Hughes.

(Standing ovation)

Governor Hughes: Thank you, Dick.

Dr. Kustrup, Mrs. Kustrup, Dr. and Mrs. Bertha, and all of you Doctors and your Wives:

I hate to miss this convivial evening of pleasure that was referred to in the Invocation prayer and it's the second time in a row, actually, that I have had this unfortunate experience of interrupting you just before you dine, but you are very kind to invite me down here to, first of all, wish The Medical Society my best on its 203rd anniversary and to express my hope that your new President, Dr. Bertha, will have a wonderful, successful tenure as your 177th President. And to finally express my admiration and respect for a fellow townsman and a friend whom I have known for very many years. I'm not going to embarrass John Kustrup by being more specific than that. It's been a very long time and during that accumulated lifetime experience I have recognized in him a man who has brought great credit to his profession, to his family, to his community, and to his State. I feel that if all of our seven million citizens knew him as well as I that all of them without exception would commission me to express this simple and brief "Well done!" to him, to wish for him and Eva and their wonderful family all of the best in the future, and I do so with a full heart.

John Kustrup is something special to me and I may tell you that all of the dignitaries, in-



Speakers' Table — Dinner Dance

cluding President Johnson of whom I was very fond, would not have persuaded me to drive down here for these few minutes tonight because I couldn't fly, I couldn't helicopter, the fog is too bad. We incidentally apologize for that. It's not typical Atlantic City weather. (Laughter) So I had to drive probably on the worst road in New Jersey and one of the things that I will try to do before I get finished being Governor is to do something about that highway. Perhaps the only thing to do would be to blow it up. It's just awful. (Laughter) But you've probably experienced it on your own travel down here.

Thank you again very much. Have a wonderful evening, and I do wish that I could stay. Thanks for having me.

(Applause)

The Toastmaster: Ladies and Gentlemen: Now that we have said hail and farewell to the Governor, may I call upon Mrs. John F. Kustrup, President of the Woman's Auxiliary, to say welcome to all of you. Mrs. Kustrup.

Mrs. John F. Kustrup: It certainly is a very distinct pleasure for me to say welcome to all of you, my friends, and my family. (We have a lot of family here.) I'd like to tell you that I have enjoyed this year so much, and thank you for giving me all the help that you have given me. It's really been wonderful. I've enjoyed serving with my husband. I think I've seen him more than I usually do.

So thank you so much, and welcome. We're happy to be with you.

(Applause)

(Introductions)

The Toastmaster: Ladies and Gentlemen: Last summer my wife and I realized a long cherished dream of visiting Ireland and one night in Sligo we were taken by our guide to a pub. It was just one of the pubs we visited, but it was the first one that I recalled with any vividness. The others were rather hazy. We went into this very long room and sat down on benches that were arranged sort of viz-a-viz. It was like sitting in the subway. You face people across the way. At first you are standoffish but after a few slugs of Irish whiskey it gets to be intimate and familiar.

Then after a while the spontaneous entertainment began. There was a microphone. The fellow who was playing the accordion served informally as MC. He said to a young chap, about twenty-two, "Tommy, it's your turn to lead off tonight. You can announce the song." So Tommy did, and rather nicely sang for us. When the applause subsided — and it was generous — the MC said: "Tommy, while you are there tell us a story."

"All right, here's a good one for you," said Tommy. "Not so long ago I had occasion to be in Belfast and in the evening I went to a pub there to get some Guinness and I was standing at the bar drinking my glass of Guinness when I felt a hand in my right pocket, down by my thigh." I turned to the fellow next to me and I said, 'What are you doing with your hand in my pocket?' He said, 'I'm looking for a match.' And I said to him, 'Why don't you ask me for it?' He said, 'I never speak to strangers'."

(Laughter)

That proscription never embarrasses us at these Presidential dinners because we are all heart deep friends. Just as we are not strangers to one another, certainly this year neither were the President of The Medical Society of New Jersey and the President of its Auxiliary. "Whom God hath joined together let not man put asunder" is an injunction which our Society in the year now closing splendidly and profitably observed. With natural graciousness in the person of Eva wedded to natural leadership as manifest in John, we had an unrivaled and unbeatable presidential team.

It has been a pleasant year of distinguished accomplishment. Each complemented the other in service, and each found obvious pleasure in the others' attainments. It is always

good for the Society and the Auxiliary if the Presidents like each other. (Laughter) But Eva and John have proved how ideal it can be when the Presidents openly, honestly, decently, and truly love one another. They have done well, and we pay them a tribute of abiding gratefulness as they prepare to surrender their offices.

The Fellow's Key and the Fellowette's Pin are the symbols of our gratitude and remembrance. Now these are to be presented. Therefore, I call upon Dr. Louis K. Collins, the immediate Past-President of The Medical Society of New Jersey, to present the Fellow's Key to Dr. Kustrup and to induct him into the noble and very select company of the Fellows of The Medical Society of New Jersey.

(Applause)

Dr. Louis K. Collins: I don't know why I always have to follow Dick Nevin with a limp microphone up here.

As you may remember, last year Joe Jehl asked the Fellows to come forward as I'm doing now — please, Fellows that can still stand and walk, assemble up here. And he said this was an inquisition. This is the beginning of an inquisition for John. Come on Fellows — Jehl, Bedrick, get up here.

The Toastmaster: Do you want the list?

Dr. Collins: I know the list. Why do you think I brought this tome along? I have it here.

And I'll tell you, Dave Allman is one of the Honorary Fellows and we had a Jefferson reception tonight and I asked Dave if he was coming and he told me why he couldn't be here. He is Mr. America and the Miss America Pageant Committee is having a meeting tonight and Dave has been the official doctor for Miss America girls for the last ninety years and he says "I don't want to get fired." And I don't blame him.

(Laughter)

So the first name in order would have been Dave Allman. And next Ken Gardner. He is not here. So, Jesse McCall, would you catch this Key, please? I ask Jesse, of the Class of 1960 in the Fellow's group, to pass the Key to Ralph Buchanan, and then to Louis Wegryn, gently, and then to Jerry Kaufman, Charlie Calvin, John Bedrick, and Joe Jehl. And then would you please pass it back to me? Would you please stay there, gentlemen?

If the Medical Society has succeeded in the past, it has been due to the leadership of these fine young gentlemen you see here.

(Applause)

Dr. Bedrick: Hallelujah.



Dinner Dance Honoring President Kustrup

Dr. Collins: Now we are very lucky that we survived the last two years when John and I were in the chair, but we did and I'm sure the future will be bright with Nick Bertha and the rest of the ones who follow.

Now you may stand up, John. (Applause) It's with great pleasure I present this Key which unlocks the door for you to join this exclusive group of Fellows. You have done a wonderful job. We are all proud of you. And Good luck and Godspeed.

(Applause)

Dr. Kustrup: I wish to thank all of you for this distinct honor and privilege. I will try to prove myself worthy of the Key as a Fellow. Thank you.

(Applause)

The Toastmaster: And now it is my pleasure to call upon the new Fellow to pin the new Fellowette of the Woman's Auxiliary. The retiring President of The Medical Society of New Jersey will present the Fellowette's Pin which is presented by The Medical Society of New Jersey to the retiring President of the Woman's Auxiliary of The Medical Society of New Jersey. And Eva has asked me to ask John to be careful in pinning it on.

(Laughter and applause)

Dr. Kustrup: This is indeed a distinct pleasure. You are about to witness a first. This is the first time a Fellow of this Society pins the Fellowette's Pin on the President of the Auxiliary as the wife of the President.

(Applause)

Dr. Collins: May I say one word, please, Mr. Master of Ceremonies? I forgot to tell you, John, that because we didn't raise the dues this year there is no engraving on the back of your Key. You will have to pay for it yourself.

(Laughter)

The Toastmaster: Ladies and Gentlemen: Now we are to have the pleasure of hearing Mr. Marko Novosel, who is an international concert singer. I should like you to know he's been selected by Dr. Kustrup who has heard him. He is managed by his brother. These two boys are the sons of a man who was a doctor of medicine and surgeon in Jugoslavija, attached to the faculty of the University of Zagreb. Mr. Novosel will announce his own numbers. Mr. Novosel.

The Toastmaster: (At the end of the musical program)

And so, dear friends, our ceremonies close.
May memories, like the sweet breath of the rose,
Perfume your days until the glad time when
In joy and friendship we shall meet again!



Mrs. Kustrup receives Fellowette's Pin From Dr. Kustrup.

AMA Convention

July 13-17 New York

Headquarters

Americana Hotel

Scientific Meetings and Exhibits

The New York Hilton

The Coliseum

THE AUXILIARY YEAR—1968-69

Saturday Afternoon, May 17, 1969

Read by the Auxiliary President, Eva Kustrup, at the opening session of the House of Delegates.



Dr. Kustrup, Dr. McCall, officers, members and guests of the House of Delegates of The Medical Society of New Jersey:

"Serving the public through our service to the medical profession" has been foremost in our thoughts and actions this year of 1968-69. The continuing rapport between the medical society and the Woman's Auxiliary with evidence of increasing respect and appreciation from physicians for our Woman's Auxiliary is heart warming.

The definition of an *auxiliary* is one who aids or helps, an assistant or associate, giving or furnishing aid, supplementary, reserve. Equipped with an engine and propeller in addition to sails. This last is the one I especially like. We would like to be your engine and propeller in addition to your sails.

Following the Eastern Regional Conference, a State conference was held with round-table discussions on AMA-ERF, community service, disaster preparedness, legislation, Medical Student Loan Fund, mental health, membership and programs and health careers and safety. The film "Horizons Unlimited" was shown. Two copies of this film were purchased and presented to the Film Library of the State Museum, Trenton, with the hope that they will be kept in constant use.

A special committee was appointed to "Study and Evaluate the Fall Conference Structure." This committee recommended that two regional fall workshops be held in the northern and southern part of the state. It also recommended an orientation program for new state chairmen to be given by the president and president-elect. This was held on May 5 in Trenton.

The Medical Student Loan Fund of The Medical Society of New Jersey has top priority with the Auxiliary. It is in its twelfth year of operation. Two hundred twenty-four loans have been granted to 134 students of New Jersey making a total of $220,244.

With pleasure we report 175 new members. This will minutely help fill the gap between our Auxiliary members and members of The Medical Society of New Jersey. Our membership now stands at 2,672. I congratulate the doctors whose wives care enough to actively work for the love of them and their profession.

We have contributed financially to WA/SAMA to send a representative from one New Jersey chapter to their National convention. They are the wives of interns and residents and our future members. We serve as their mentors.

Health career scholarships and AMA-ERF have firm financial support from the counties. Please read the reports of the chairmen.

Our State publication *The Shingle* has informed all members of the activities of the State and county auxiliaries and is a means of communication for the President. Six issues were published.

Information on current medical legislation was given to members. Letters were sent to Governor Hughes asking that he veto Senate Bills #363 and #365 dealing with chiropractic, and that he further investigate this in the public interest. This he did. The Executive Board of the Auxiliary to The Medical Society of New Jersey visited the State Legislature in March and was publicly recognized while the Legislature was in session.

An increase of two dollars per member will be sent to the National Auxiliary beginning in 1970. Dues for National will then be four dollars. The State Auxiliary did not request an increase in State dues which are two dollars per member.

Many health related educational programs have been successfully conducted by the counties often in cooperation with other organizations which share common goals. One county auxiliary helped sponsor a two day health fair in cooperation with the county medical society and the Department of Health. County auxiliaries have assisted their medical societies in the yearly eye-screening program, worked on drives such as heart, tuberculosis, Red Cross, poliomyelitis, cancer, venereal disease, drug addiction and medical problems of the aged. Auxiliaries have helped conduct a seminar on water pollution.

This has been a wonderful year for me. I have been to all twenty organized counties and am delighted with their programs and progress. There is a fine feeling of friendship and dedication among the doctor's wives.

Visits to Pennsylvania, Delaware, New York, and Maryland at their conventions and workshops were informative and pleasant. I was proud to be your representative and was treated with the utmost thoughtfulness and respect.

The staff at our headquarters in Trenton was most helpful. Our secretary, Mrs. Shirley Walsh is indispensable and I could not have done without her. Mr. Richard I. Nevin, Executive Director of The Medical Society of New Jersey, is a true friend to me and to the Auxiliary. I was blessed with an able, lively dedicated Board and I do want you to read their fine reports.

Most of all, I thank you for allowing me to serve with my husband, John F. Kustrup, president of The Medical Society of New Jersey, whose dedicated leadership and council has inspired me to do my very best.

46th Annual Convention

Woman's Auxiliary to the American Medical Association

July 13-17 New York

Headquarters—Waldorf-Astoria Hotel

A cordial invitation is extended to members of the Women's Auxiliary to the AMA, their guests, the wives of AMA Delegates and Alternates, and guests of physicians attending the AMA Convention to participate in all social functions and to attend the general meetings of the Auxiliary.

ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Registration:			
Total Possible — Officers, Fellows, and County Delegates			376
Total Possible of County Delegates		355	100%
Total County Delegates Registered		337	94.9%
Attendance of County Delegates at the House Sessions:		% of Possible	% of Registered
1st Session, 5/17/69	(287)	80.8	85
2nd Session, 5/18/69	(315)	88.7	93.5
3rd Session, 5/20/69 A.M.	(294)	82.8	87.2
P.M.	(234)	65.9	69.4
Average for all Sessions	(283)	79.7	84

Official Attendance Report

County	Delegates	Members	Total
Atlantic	6	56	62
Bergen	39	34	73
Burlington	8	12	20
Camden	21	27	48
Cape May	3	5	8
Cumberland	4	12	16
Essex	73	138	211
Gloucester	4	7	11
Hudson	26	29	55
Hunterdon	1	5	6
Mercer	23	55	78
Middlesex	17	32	49
Monmouth	18	45	63
Morris	18	32	50
Ocean	5	11	16
Passaic	29	30	59
Salem	3	8	11
Somerset	5	5	10
Sussex	3	—	3
Union	28	36	64
Warren	3	3	6
Fellows and Officers	17	—	17
	354	582	936

Physician Guests	76
Physician Exhibitors	29
TOTAL PHYSICIAN REGISTRATION	1,041
Auxiliary	458
Visitors	331
Exhibitors	284
TOTAL REGISTRATION	2,114

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1969	1,041	1,073	2,114
1968	1,112	1,176	2,288
1967	1,017	1,018	2,035
1966	1,024	1,135	2,159
1965	1,019	1,046	2,155



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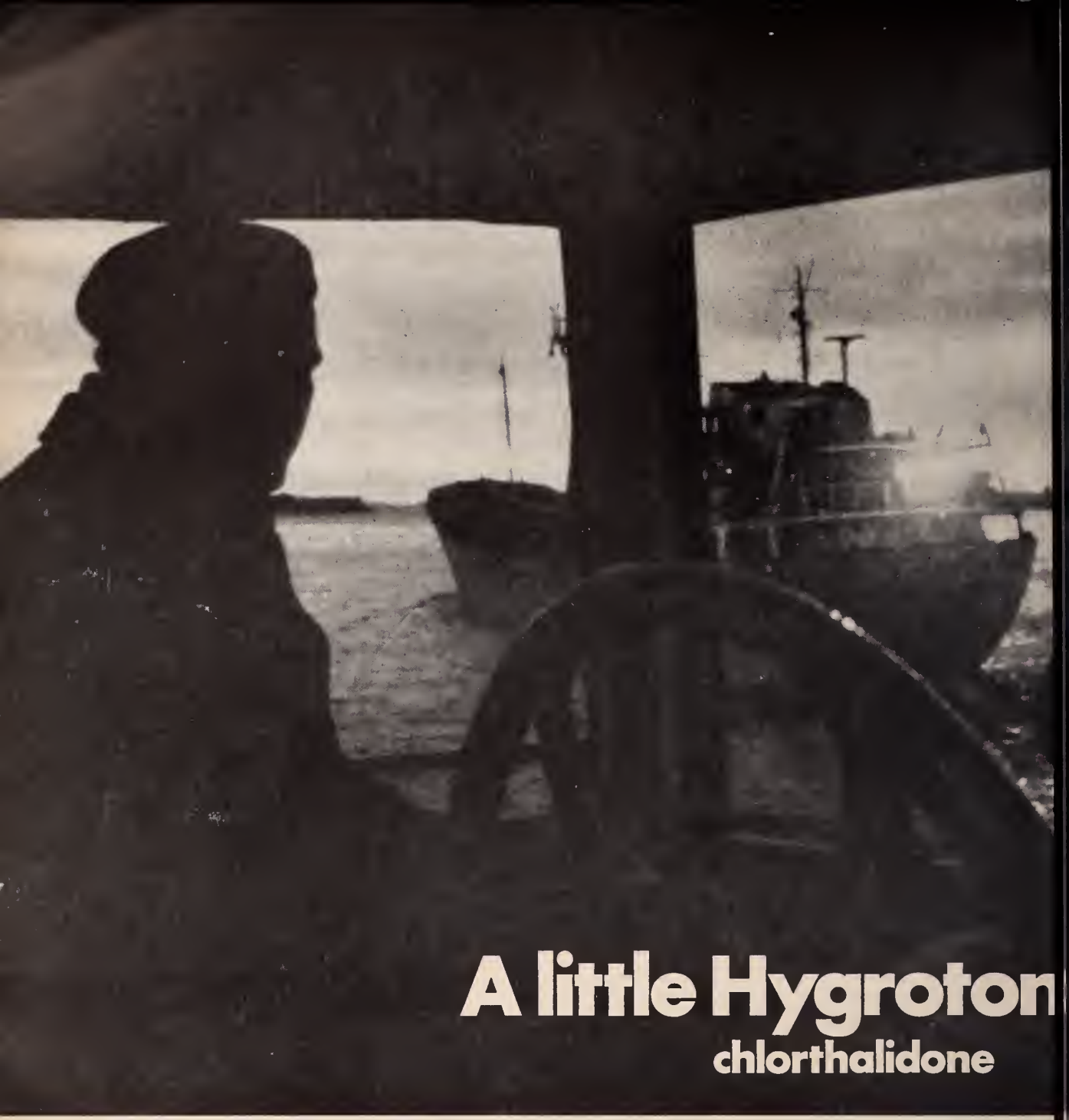
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Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy potients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric poin or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

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In the complex picture of moderate to severe anxiety...



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Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

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Beginning this September and ending the last Wednesday in May 1970, the Fourteenth Postgraduate Course "Recent Advances in Internal Medicine and Therapeutics" will be given at Middlesex General Hospital in New Brunswick. As in previous years, the Course is designed to provide clear and concise reviews of important new advances in aspects of internal medicine which are of practical interest to internists and general practitioners. The Course provides university credit toward meeting the requirements of the AAGP (totaling 68 points for the 34 sessions).

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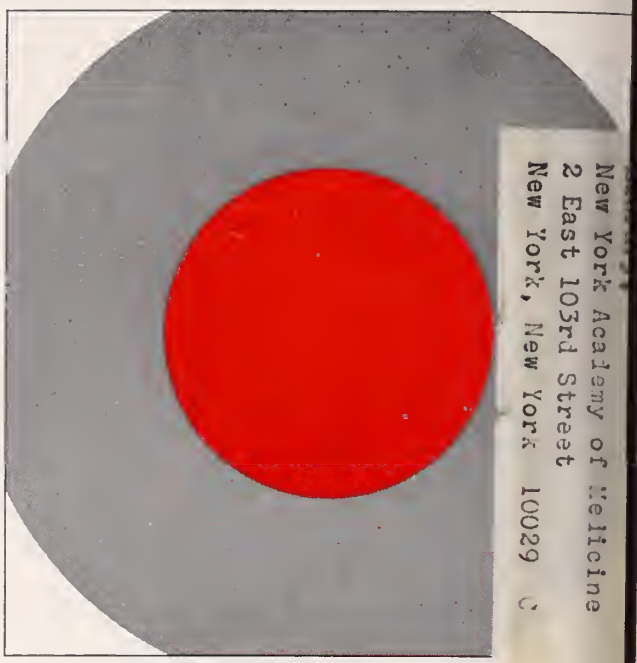
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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

BALCONY

the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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AUGUST 1969
VOL. 66, NO. 8

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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

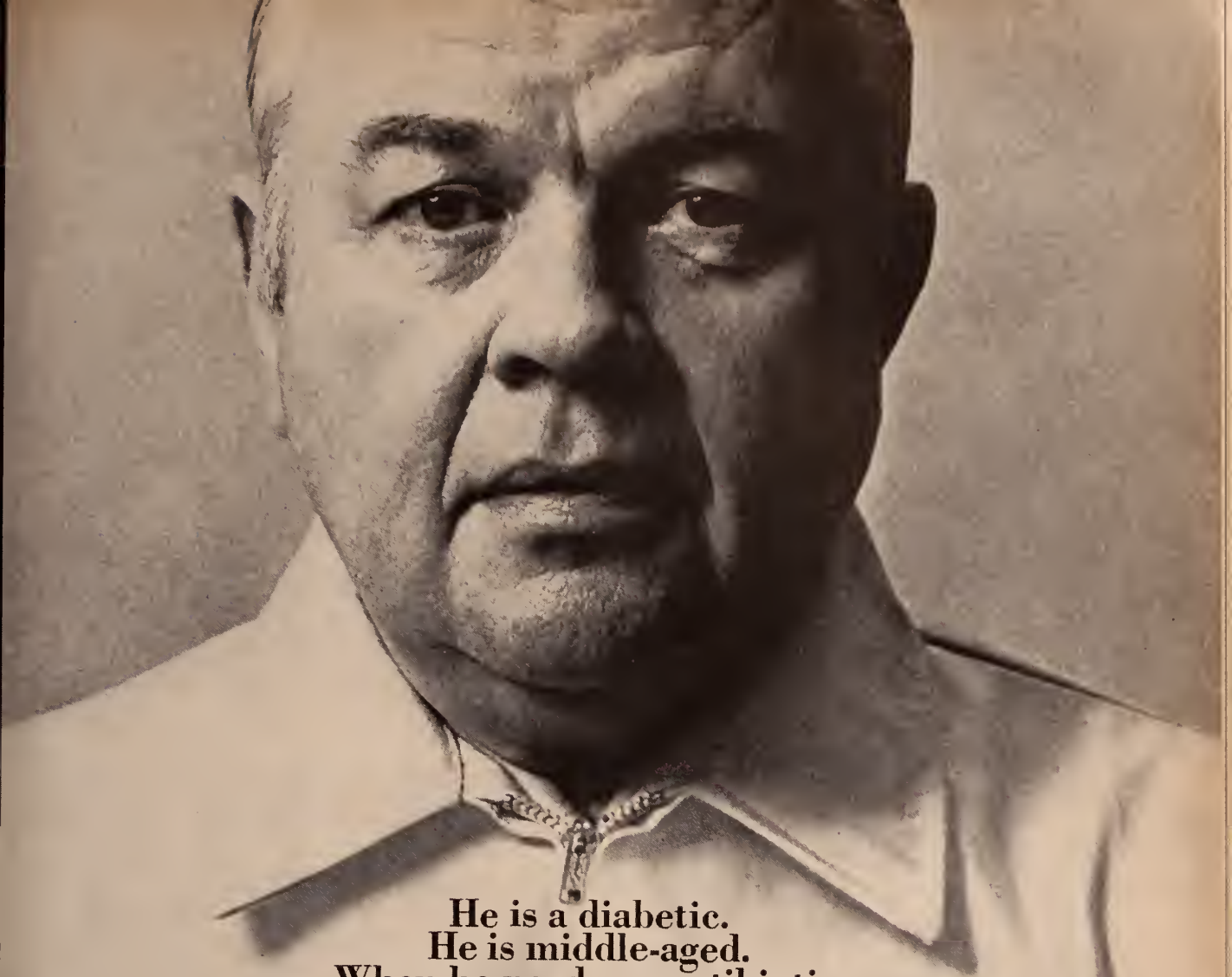
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

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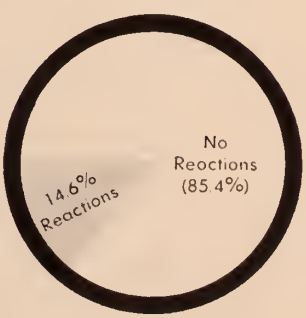


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*Summary of results from three studies. References available on request.



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or here.



). Though generally not recommended, if bination therapy with other psychotropics is indicated, carefully consider individual rmacologic effects, particularly in use of po- ating drugs such as MAO inhibitors and othiazines. Observe usual precautions in ence of impaired renal or hepatic function. doxical reactions (*e.g.*, excitement, stimula- and acute rage) have been reported in psy- tric patients. Employ usual precautions in ment of anxiety states with evidence of im- ling depression; suicidal tendencies may be nt and protective measures necessary. Vari- effects on blood coagulation have been rted very rarely in patients receiving the and oral anticoagulants; causal relation- has not been established clinically.

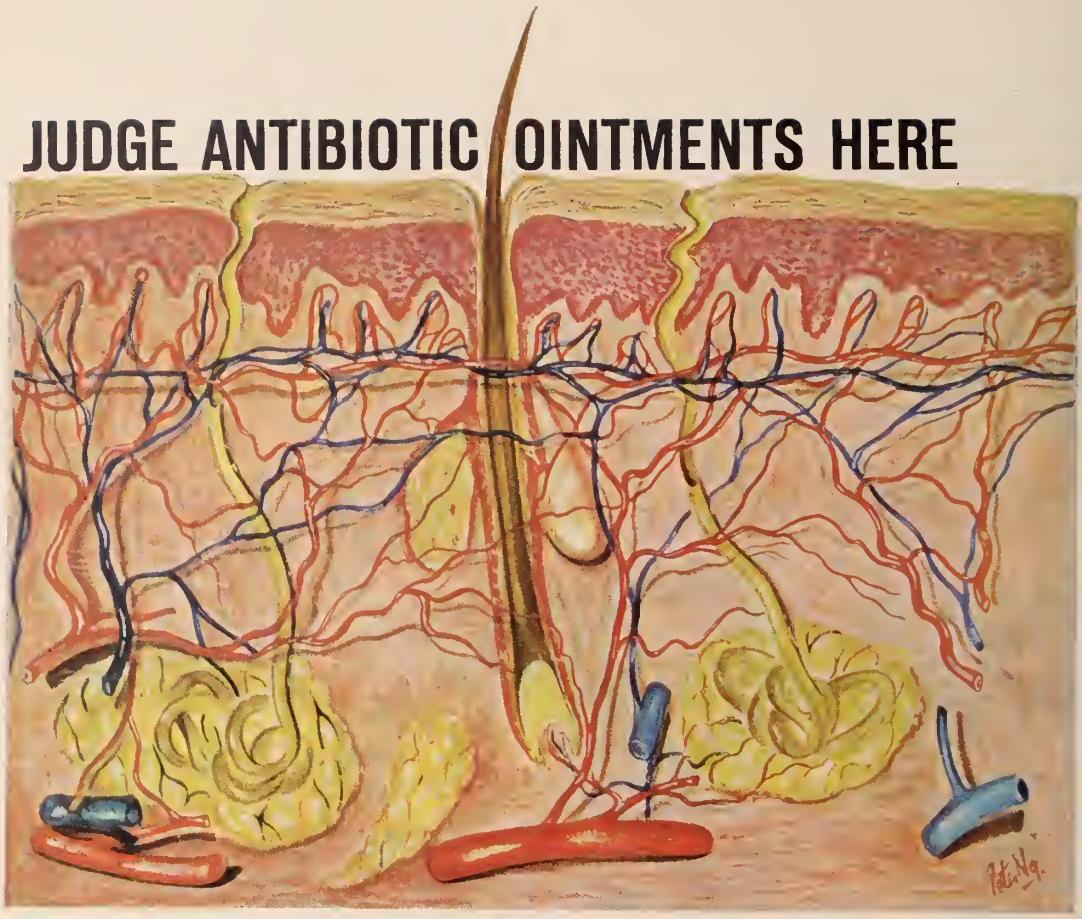
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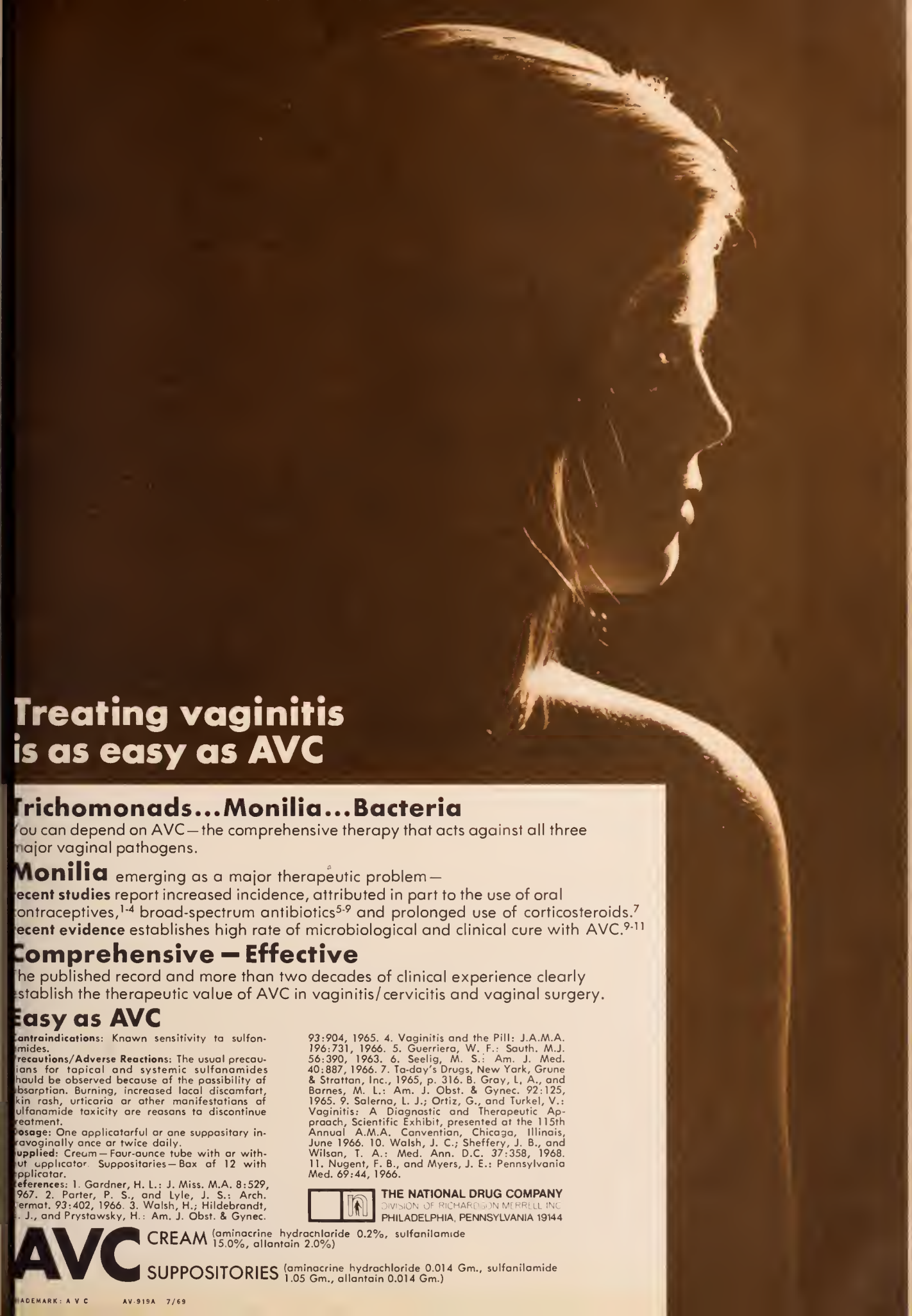
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, J. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-day's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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Use with caution in pregnant women and nursing mothers since the drug may cross the placental borrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympothectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbolance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, poresthesia, and photosensitization.

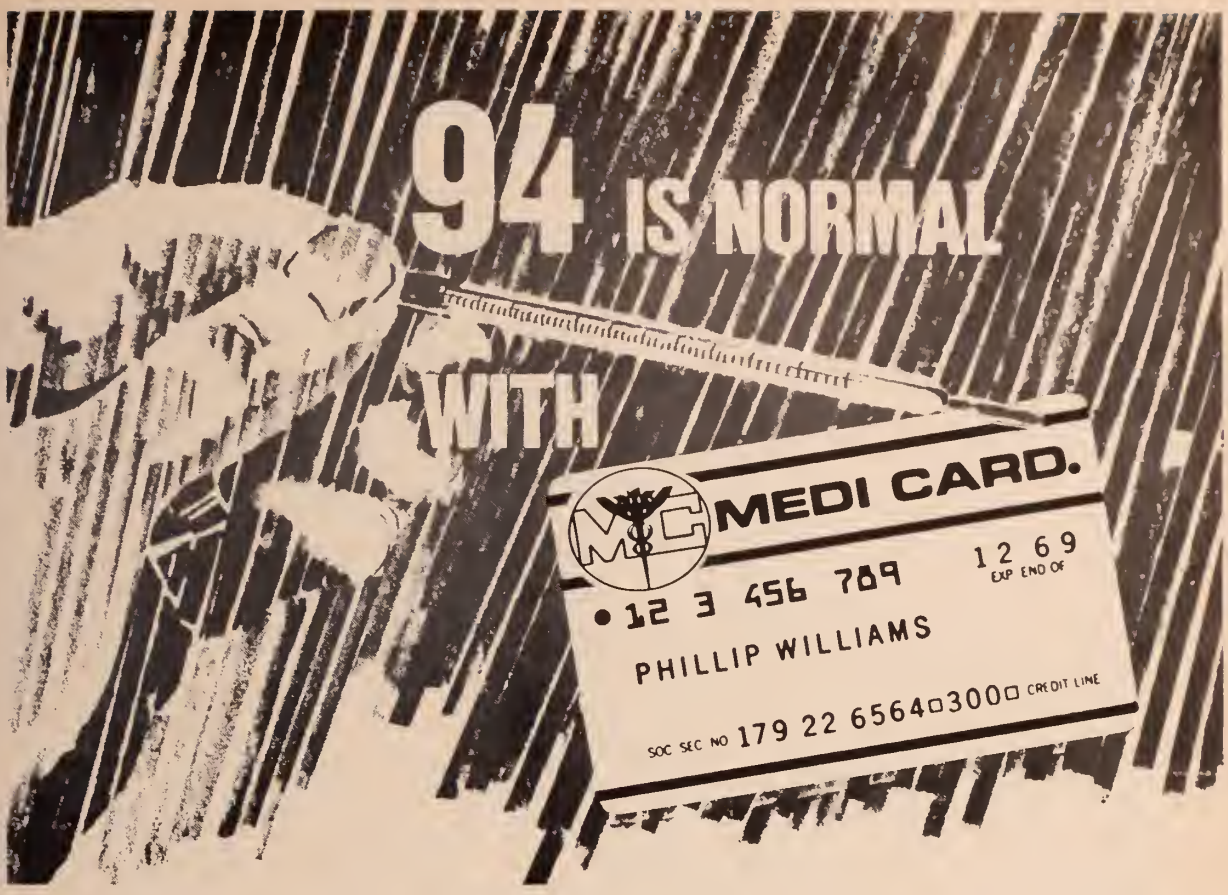
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EDITORIALS

The Rod Of Comfort

"Thy rod and thy staff they comfort me." So it is written in that most solacing an poignant of poems, the 23rd Psalm. Physicians are the lineal descendants of the priests who carried the rod and staff of comfort. And the symbol of medicine is the snake-entwined staff, the caduceus.

It seems pointless to argue whether you will take your caduceus with one snake or two. Historical theorists say that there is a difference — Aesculapius was associated with the one-serpent staff, since, legend says, he had to stamp out a snake with the stick — and the snake crawled up and entwined itself around the staff. A patient had apparently been killed by a thunderbolt, and the snake somehow revived him. Snakes were supposed to be immortal anyway — they seem to be reborn annually. When Aesculapius himself died, he became a star, still visible in the southern heavens. The astronomical name for that star is Ophiuchus: the snake-bearer.

Caduceus is a Latinization of a Greek form meaning "wand-bearer," not "snake-bearer." The reference was to the staff carried by messengers. The messenger of the gods was Mercury — or, if that is not all Greek to you, Hermes. At first he carried a simple olive branch (symbol of peace, as befits a herald who takes messages but does not take sides). One day he saw two snakes fighting. He pushed his staff between them to separate the combatants, using the olive branch again in its pacific function. The snakes crawled up the stick, glared at each other across the top of the staff, but were kept from fighting by the firm rod between them. So was born the caduceus — the two-snaked rod, which compulsively pure historians distinguish from the one-snaked staff of Aesculapius.

At any rate, it was all part of ophism — snake worship. We think of snakes as death-dealing animals as, indeed, many of them are. But snakes were associated in primitive minds with life-giving. There was the annual renaissance of the snake — or so it seemed. Primitives recognized the therapeutic power of some snake venom. Also the snake seemed magic — it could crawl into the earth — vanish — reappear. There were snake charmers who could do wonders with these graceful beasts. Snake dances were part of the religious ritual in many widely separated cultures. Some snakes could breath fire — these were called dragons. Snakes appear frequently in the Bible, usually under the synonym "serpent." So the snake became a symbol for fertility and shrewdness, recovery, and longevity. Snakes, serpents, and dragons appear in the iconography of many countries and cultures: the headdress of the Pharaohs, the flag of old China, the cult of the Hopi Indians, the cobra culture of the Buddhist, and the pantheon of the Minoans—all saluting this strange animal.

Display of the caduceus as a medical insigne is relatively modern. In the U.S. civil service, specifically the U.S. Public Health Service, the caduceus was first used in 1858. The Army did not adopt it as a medical insigne until as late as 1902. In the Navy, it does *not* symbolize the medical officer. The A.M.A. did not incorporate it on their emblems until 1912.

Snakes are associated with healing among the Indians of America and among the Indians of India. In 19th century America, the vendor of "snake oil" as a panacea was a common part of the scene. It was usually advertised as an old Indian Snake Oil, attesting to its double potency — bearing the approval of sage folk like the Indians but also drawing some of its power from association with snakes. And the Indians of Asiatic India have, for centuries, made an extract from a snake-plant to cure madness and relieve dizziness. This plant, *Rauwolfia serpentina,* really has nothing to do with snakes except that its root looks snakey — which is what the *serpentina* means. But it inherited some of the mystery of ophism — and then, much to the surprise of modern chemists, it was found that the root really contained potent alkaloids. The best known, reserpine, displays in its name the ubiquitous

serpent; re*serp*ine. Its heritage includes the other Indian snake root, beloved by last century's American medicine men. So we come full cycle: the primitive serpent with its mythical powers of fertility, rejuvenation, and shrewdness; the modern snake-root with its versatile tranquilizing and hypotensive effects; and in between the iconographic snake that entwines itself on the rod and the staff and forms the comforting symbol of the healing art.

The Anatomic And Pathologic Society

Elsewhere in this issue (page 479) we publish what Dr. Berg calls a "belated obituary" on the Essex County Anatomic and Pathologic Society. This Society was really New Jersey's only forum for basic medical education in the fundamental fields of pathology and anatomy. Internationally famous practitioners and professors considered it an honor to be invited to speak at its Annual Meeting. There is no doubt that Harrison Martland was the axis around whom the Society for so long revolved. Dr. Martland was one of the too-few New Jersey practitioners to achieve worldwide medical renown. And the Essex County Anatomic and Pathologic Society did not long survive his death. Dr. Martland died in 1956 and the Society died in 1967. Some felt that the Society had developed a sort of personality cult with Dr. Martland as *the* personality. It was not quite like that, however.

Until the end of World War II, few New Jersey hospitals felt that they had any teaching responsibilities. They were busy enough taking care of the sick and injured. But with the realization that a good hospital must be a teaching hospital came the development of professional educational programs in hospitals. Then too, there was the burgeoning of specialty societies, and finally the entry of two medical schools in a state that had for two centuries gotten along without any. This all so diversified the educational function that the Anatomic and Pathologic Society seemed outdated. We wonder, however, if in their very diversity, the various institutions and agencies that have assumed the educational burden, are going to do as well as the old Anatomic and Pathologic Society which, for five decades carried aloft — and almost alone — the torch of learning.

Psychosomatics By Inference

While most doctors now acknowledge emotional factors in organic disease, there is still a reluctance to write such things down on paper. It is easier to write "peptic ulcer" on an office or hospital record than to say that the symptoms are basically due to "frustration with resultant hyperacidity." While this is a more meaningful formulation than "peptic ulcer," it just isn't the kind of thing that gastroenterologists and surgeons put down on their consultation reports.

It is as if medicine, being dedicated to the care and cure of the body, has to maintain its intraprofessional communications along "organic" lines. Or as if the doctor were afraid of being laughed at if he placed a psychological explanation on a hospital consultation sheet. He knows that anger can raise the blood pressure and that repressed hostility can increase gastric acidity. Everybody else knows it too. But a curious conspiracy of silence seems to prevail. Elaborate chemical studies are made of the gastric acidity and solemnly entered on the hospital chart, while the more significant emotional factors are discussed orally but never written into the records.

It is a kind of make-believe communication. The chemical and pathologic changes constitute the surface language while the psychological explanations of illness are understood by inference. This double talk seems to be necessary because the psychosomatic concept has penetrated the thinking of doctors but not their language.

ORIGINAL ARTICLES

For exotropia, early surgery is indicated. While residual exo-deviations tend to worsen in time, over corrections tend to improve.

Surgery Of Exotropia*

A. G. Portfolio, M.D./Ridgewood

Exotropia embraces both intermittent and constant outward deviations of the eyes. Also included in the classification of "exo" deviations, is exophoria. This seldom, if ever, requires surgical correction. Therefore, I shall discuss the surgical treatment of only intermittent exotropia and constant exotropia.

Intermittent exotropia is an outward deviation of the eyes. It is sometimes latent and at other times manifest. The proportion between these types depends on the degree of temporal hemi-retinal suppression present. If suppression is slight, the deviation may be latent much of the time. If suppression is deep-seated the deviation may be manifest most of the time and indeed become constant.[1] Usually these deviations are greater for distance gaze than for near gaze and therefore represent divergence excess. But this may be more apparent than real. If these patients are measured with +3.00 lenses at near relaxing accommodation, the near measurement often approximates the distance measurement. The same effect may be produced by dissociating the eyes with a patch for one-half hour. The patch disrupts fusional convergence. These vergences i.e. fusional and accommodative convergence can reduce the angle of deviation at near, thereby producing a simulated or pseudo divergence excess.[2] Pure divergence excess which is not affected by occlusion or plus lenses "at near" is not common. Divergence excess and convergence insufficiency may exist simultaneously (basic exotropia). In time, the "near" measurement may approximate or exceed the distance measurement. These patients with intermittent or constant exotropia differ then from pure exophoria patients inasmuch as they have suppression and it is this adaptive mechanism which leads the ophthalmologist to intervene.

Treatment of Intermittent Exotropia

Antisuppression treatment prior to surgery may be helpful. This can be carried out by an orthoptist if the child is old enough; otherwise the fixing eye can be patched. Orthoptics is continued until the patient can recognize diplopia whenever the eye deviates out. Amblyopia is likewise treated but no vergence training is carried out prior to surgery. In young children where patching has been done (and where subjective response is impossible) an improved recovery following dissociation of the eyes indicates treatment has been successful. It can also be noted that after antisuppression treatment the patient's control of his deviation is often improved and the actual measurement of his deviation less. This is usually temporary as the deviation will again increase as suppression returns. Occasionally preoperative antisuppression training is unrewarding due to lack of cooperation or due to deep suppression. In these instances, surgical intervention to upset the sensorial mechanism is indicated followed by orthoptics if possible. The use of orthoptics pre- and postoperatively, has fallen into disfavor in some areas but there is no doubt of its merit in certain cases.

* Read before the Section on Ophthalmology of The Medical Society of New Jersey, Atlantic City, May 19, 1969. Dr. Portfolio is Associate Clinical Professor of Ophthalmology at the New York University School of Medicine.

The surgical treatment of intermittent exotropia is either recession of the lateral recti, resection of the medial recti or recession of a lateral rectus with resection of a medial rectus. The patients are measured at distance, far distance, and near, up and down, in levo- and dextro-version and in the oblique fields of gaze by fixing an accommodative target. Particular attention is paid to measurements in primary position, up, down, an lateral gaze in distance. If measurements in lateral gaze are less than in the primary position and abduction is not full, a little less surgery of the lateral recti is done if symmetrical surgery is planned. Measurements are done with +3.00 lenses at "near" — if this increases the near deviation significantly it indicates a high AC/A ratio. This being so, some would do a recess resect operation rather than a bilateral recession of the laterals. Others would still recess the laterals. If the "near" measurement is negligible and does not increase with plus lenses or patching one might do a little less recession of the laterals than usual. Some surgeons would in this instance recess one medial along with recession of the laterals (Sugar procedure). I have had no personal experience with this. What procedure one will do depends to a large extent on the type of deviation: whether it is greater for distance than near; whether it is greater for near than for distance, or whether it is the same for distance and near.

It will also depend on one's particular philosophy regarding eye muscle surgery. Some ophthalmic surgeons prefer symmetrical extraocular muscle surgery; others prefer the recess-resect operation. We follow the traditional approach of classifying our motility problems according to Duane's anomalies of vergence, and then operate on the appropriate muscles. Thus in divergence excess or simulated divergence excess we would recess the lateral recti. In divergence excess with secondary convergence insufficiency (basic exotropia), we do a recess-resect operation. In convergence insufficiency, we resect the medial recti. Pure convergence insufficiency without basic exotropia is an orthoptic rather than a surgical problem. The important thing is not so much the technic used, but rather the accomplishment of our objective, which is to rid the patient of his deviation. If the deviation is large, we prefer two-stage procedures a few months apart rather than operating on four muscles at one sitting. It seems desirable to overcorrect exo-deviations because these patients remain better aligned over the years. However, titrating over-corrections so that they are small rather than large is impossible. Over-corrections of small degree (between 1 and 20 prism diopters) are considered beneficial and generally, in time, either spontaneously or with medical treatment, will disappear. Larger over-corrections (over 20 prism diopters) may require additional surgery but in the absence of some surgically induced mechanical obstacle it is wise to wait a year or more before intervening. Some of the smaller over-corrections may be treated with glasses and/or miotics if a high AC/A ratio is present. Prisms, patching, and orthoptics also may be tried. Most of the unsatisfactory results are due to under-corrections rather than over-corrections. Significant vertical deviations are treated at the same time as horizontal muscle surgery is done. A vertical deviation is often present for distance but cannot be found at near nor in the cardinal positions of gaze. These are not operated but are generally improved with correction of the horizontal deviation.

At what age does one operate intermittent exotropia? This depends on the amount of deviation and the control of the deviation. If the deviation is small, less than 20 prism diopters, and control good, one can delay surgery as long as the child can be followed periodically, provided there is no worsening of the deviation. Larger deviations should be done as soon as it is feasible. One has to consider, in small, well-controlled deviations, the possibility of converting an intermittent exo-deviation into a constant eso-deviation in early childhood and its subsequent adverse effect on the development of fusion.

Etiology of Exotropia

Constant exotropia may be the end result of intermittent exotropia, may be congenital, may

be due to deformities of skull and orbits (such as hypertelorism or oxycephaly) abnormalities of medial recti or to some sensory obstacle in one eye. In addition, there are those patients who were formerly esotropic who become exotropic either following surgery or spontaneously due to the absence of stable binocular vision.[3]

Treatment of Exotropia

The treatment of constant or consecutive exotropia is surgery preceded by antisuppression and amblyopia treatment in younger patients. These are operated on essentially as the intermittent exotropes, by recession of lateral recti or recession of lateral rectus and resection of medial rectus or resection of medial recti. Post-operative exotropes are evaluated as new cases and re-operated accordingly. Post-operative exotropes who are still exotropic after multiple operations can present a problem inasmuch as scarring of tenon's, conjunctiva, and fibrosis of extra-ocular muscles may result in a relatively frozen eye. These patients require excision of scar tissue, conjunctival grafts or recession of conjunctiva (bare sclera closure technic), and immobilization of the eye toward the field of apparent weakness in addition to the surgery of the extra-ocular muscle. This may result in improvement but lack of full ocular motility. The congenital exotropes are operated early just as are the congenital esotropes.

A-V Syndrome

Intermittent or constant exotropia with A or V syndrome is operated on according to the presence or absence of oblique dysfunction. In the absence of oblique dysfunction, the horizontal recti are displaced toward the field of greater horizontal deviation if the muscles are to be recessed; or toward the field of lesser horizontal deviation if the muscles are to be resected. Thus in V exotropia in which recession of the lateral is indicated, the muscles would be supraplaced as well as recessed. If resection of the medial rectus is indicated, the muscles would be infraplaced as well as resected. In V exotropia with overaction of inferior obliques, the latter are recessed or disinserted as well as doing appropriate horizontal rectus surgery. In A exotropia with overaction of the superior obliques, the latter are tenectomized as well as doing appropriate horizontal muscle surgery. In some instances, monocular displacements of horizontal recti may be effective in improving an A or V syndrome.

Summary

Early surgery is indicated in most cases of intermittent and constant exotropia. The most favorable results are those in which no exo-deviation or slight eso-deviation remains. Residual exo-deviations tend to worsen in time whereas over-corrections tend to improve with the passage of time.

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20 Wilsey Square

Detection Of Impending Failure In Pacemakers*

As implantable pacemakers last a variable time, it is desirable to be able to foretell when each individual pacemaker is nearing the end of its life. A test which detects a number of different impending electronic failures including battery depletion is described. The test requires only standard laboratory equipment and has been used for four years as a three-monthly procedure in an out-patient clinic. In 17 of 19 consecutive patients the test has enabled a change of pacemaker to be carried out electively, rather than after an arbitrary period or as an emergency when pacing has failed.

— Davies, J. G. and Siddons, H.: *Thorax* (London), 24:74 (January 1969)

Here proposed is a practical plan for measuring the effectiveness of graduate medical education.

Continuing Education For Psychiatrists*

Robert S. Garber, M.D./Belle Mead

Continuing medical education is a misnomer. Most programs so labeled today are neither continuing nor educational. Usually they are one-day symposia or isolated programs.

Physicians have become increasingly concerned with the need for effective, continuing educational opportunities in order that advances in medical knowledge may be quickly applied in their practices. But there has been a lack of basic guidance on what educational approaches would be most useful.

To explore the problems of continuing medical education and generate possible solutions, the American Medical Association decided that it should have the advice of leaders in the profession. The Council obtained authorization in 1956 to appoint an Advisory Committee on Graduate Medical Education. This Committee published a guide[1] on objectives and basic principles of continuing medical education programs. Purpose of the guide is to present the objectives and basic principles of graduate medical education for the guidance both of those *active* in the field and those desiring to *initiate* courses and other programs for the continuing education of physicians. After all, new discoveries in the struggle against disease are of little practical use until the clinician learns about them and how to apply them. No matter how well prepared a physician may be when entering practice, knowledge that was adequate yesterday is not fully adequate today. In 1952, the AMA Council on Medical Education had initiated a study of graduate medical education. Results of this survey are in the Vollan Report.[2]

Continuing educational programs should make possible the acquisition of new skills in the field of original competence. Continuing education should strengthen the habits of critical inquiry and balanced judgment that denote the truly professional and scientific man.

Since the 1955 appearance of the Vollan Report[2] many pertinent articles on the subject have appeared. These reports stress the importance of continuing education for all physicians *after* they have completed their graduate education. For example, Dryer[3] titled his 1962 report "Lifetime Learning for Physicians." The Coggeshall[4] report of 1965 pointed out that the present-day physician is not a finished product and must accept continuous education and re-education. The hue and cry from communications media has led to national public criticism, implying that society needs protection from any practitioner who neglects his continued education or from those whose basic competence is questionable. The Coggeshall Report was followed the next year by the report of the Mills Commission,[5] the citizens' commission on graduate medical education. It suggested the possibility of repeated examinations for the updating of medical licenses.

Thus, the idea of renewing the physicians' education program emerged from Vollan's important contributions. He was able to identify the obstacles and deterrents to physicians' participation in continuing education programs. He listed these obstacles:

* Read before the Southern Psychiatric Association in Atlanta, Georgia, October 7, 1968.

1. No one to care for patients while a doctor is away from his practice.

2. Courses given at unsuitable times.

3. The cost involved — both loss of income and the cost of the course.

4. Multiplicity of other meetings — placing a demand on the doctors' already limited time.

5. The subject matter so often not meeting his needs.

6. A lack of courses in the physicians' geographic area.

7. Previous unsatisfactory experience with poor courses.

8. A lack of information about courses.

These so-called deterrents were actually the cornerstone of Storey's report[6] on the feasibility of the American Medical Association's proposal to establish a national plan for continuing medical education. In his presentation, Storey isolated three unknown areas for closer inspection:

1. *The Clinical Needs of the American People.* Data on the needs of the patients, the diseases which brought patients to the doctor's office or to the hospital were surprisingly meager.

2. *The "Knowledge Explosion."* The disappearance of the single-authored text book, the growth of specialism, the redefinition of the general practice of medicine, the development of clinic-type practice all contribute to the pressing need for a solution to the problem of continuing medical education.

3. *Efficiency and Physician Accomplishment.* Continuing medical education is needed where both clinical needs and medical knowledge are not properly synthesized by the physician into a solution of patient problems. Graduate medical education reflects a well endorsed need. Voluntary health agencies, professional societies and medical schools are all involved effectively in this area. Although a listing is incomplete, the American Medical Association, state medical societies, medical journals, books, and films have essential roles to play in the continuing education of physicians. One of the major factors in stimulating interest and activity has been Public Law 89-239. This legislation authorizes regional medical programs in heart disease, cancer, and stroke. This has directed public attention to the problem of *maintaining* professional competence and has provided the first significant allocation of federal funds for support of continuing medical education. As a result, many medical schools, community hospitals and other institutions are developing new programs or strengthening and expanding existing programs.

While the legislation relates only to heart disease, cancer, and stroke, the suppprt which it provides for the development and administration of educational programs will be applicable to continuing education in all areas of medicine and the allied health professions. This influence of regional medical programs in the field will be major. Nevertheless, there remains a major challenge of self-renewal which no existing mechanisms solve. Specifically, how can a busy physician obtain in-depth training at the bedside and learn entire new skills? This question is posed by Diamond[7] in his report, "A National Graduate Medical Center," in which he proposed the designation of one or more Veteran Administration hospitals as national graduate medical centers.

The following tables from the *Journal of the American Medical Association*[8] are useful to get some idea of number, type, sponsorship, and participation ratio in continuing medical education courses.

TABLE 1 — CONTINUING MEDICAL EDUCATION COURSES LISTED, 1961-1962 to 1967-1968

Year	Total Courses Reported	No. of Primary Sponsors	Courses Offered by Medical Schools	Courses Offered by Hospitals
1961-1962	1,105	206	....	....
1962-1963	1,146	208	626 (55%)	104 (9%)
1963-1964	1,264*	267*	760* (60%)	163 (13%)
1964-1965	1,569	251	857 (55%)	265 (16%)
1965-1966	1,641	252	863 (53%)	351 (21%)
1966-1967	1,608	262	910 (57%)	338 (21%)
1967-1968	1,830	263	1000 (54%)	224 (12%)

The figure of 1,830 courses represents a 14 per cent increase over the number reported for the previous year. The number of courses

* Includes courses offered by 5 Canadian schools not reported in other years.

reported had dropped in 1966-1967 for the first time in more than five years. The 1967-1968 number now shows a significant increase once more and restores the annual increment of approximately a 5 per cent increase each year.

TABLE 2 — SPONSORS AND CO-SPONSORS OF CONTINUING EDUCATION COURSES, 1967-1968

Medical Schools	71
Non-School Hospitals (Includes government hospitals)	201
County and State Medical Societies Academies of General Practice and Graduate Medical Assemblies	35
Academies of Medicine and Specialty Medical Societies	27
Voluntary Health Agencies	7
Other (includes postgraduate medical schools; city, state, and federal government agencies, other than hospitals)	46
TOTAL	387

The largest group was the non-affiliated hospitals, including government hospitals, which numbered 201 (compared with 215 in the previous year), or 12 per cent of the total. These numbers have declined from 338 courses, or 21 per cent of the total in 1966-1967.

Increasing numbers of community hospitals are developing affiliations with medical schools under the regional medical programs. Therefore, more continuing education courses are being offered with the medical school as primary sponsor rather than the community hospital. The programs of medical schools are much more extensive in that the average number of courses offered by a medical school is 14 while that for the community hospitals is only a little more than one per hospital.

As in past years, continuous courses are the most common in type. The number of these courses has grown to 1,205, which is exactly the same percentage (66) as that offered in recent years. Only 28 per cent of the courses are scheduled intermittently, with by far the largest number of these in the field of psychiatry. Seventy-nine per cent of the courses offered in psychiatry are given on an intermittent basis. It is usually inconvenient for physicians to come from long distances at intermittent intervals over long periods. For a continuous course, on the other hand, physicians may travel long distances to spend a concentrated period in formal study.

TABLE 3 — NUMBER AND PROPORTION OF ALL CONTINUING EDUCATION COURSES BY TYPE OF COURSE

TYPE	Total No.	%	General Medicine	%	Psychiatry	%	Total Minus GM & Psych.	%
Continuous	1,205	66	130	60	62	18	1,013	79
Intermittent	524	28	60	28	261	79	203	16
Postgraduate Traineeship	54		5		7		42	
Home Study	16		1		0		15	
Circuit Course	15		7		3		5	
TV-Radio	15		11		0		4	
Other	0		0		0		0	
Not stipulated type	1		0		0		1	
TOTAL	1,830		214		333		1,283	

TABLE 4 — NUMBER AND PROPORTION OF ALL COURSES BY TYPE OF PRACTICE OF PHYSICIANS FOR WHOM COURSES WERE DESIGNED — 1967-1968

TYPE	Total No.	% of Subtotal	General Medicine	%	Psychiatry	%	Total Minus GM & Psych.	%
Specialists	189	27	1	0.5	63	20	425	33
Physicians in General and part-time Specialty Practice	315	17	73	36	47	15	195	15
Both	1,004	56	130	63.5	212	65	662	52
SUBTOTAL	(1,808)		(204)		(322)		(1,282)	
Not stipulated in course listing	22		11		1		10	
TOTAL	1,830		215		323		1,292	

Table 4 lists the number and proportion of all courses by type of practice of physicians for whom courses were designed. The figures for 1967-1968 confirm the trend toward a single class of continuing education courses at which all physicians, whether specialists or generalists are permitted to attend.† For 1967-1968, 56 per cent of all courses are open to both specialists and generalists, compared with only 11 per cent in 1956-1957. The ratio is even higher for courses offered by medical schools, with 63 per cent of medical school courses designed for both specialists and physicians in general or part-time specialty practice.

TABLE 5—NUMBER OF REGISTRATIONS AT CONTINUING EDUCATION COURSES OF AMERICAN MEDICAL SCHOOLS

Year	Registrations	No. of Schools Reporting
1954-1955	18,819	49
1956-1957	19,726	**
1958-1959	39,817	**
1961-1962	57,530	63
1963-1964	71,000	43
1964-1965	88,845	56
1965-1966	95,284	64
1966-1967	100,822	65

All academic organizations, as well as industrial and voluntary agencies, state and federal governments, have increased their commitment to continuing education in attempts to cope with the ever-increasing supply of new knowledge. Unfortunately, as pointed out in *Educom*,[9] it seems that such activities may be built more upon a sense of urgency to do something than what is needed and what can be done with a target population of practitioners. The model used seems to be designed for academic instruction rather than for continued learning, and the education is more episodic than continuing. It appears that each profession and each institution pursues an independent course and rarely examines the experiences of others or communicates their successes and their failures! *Educom*[9] proposes a future study of continuing education, which will look at the whole area of lifetime learning for professions in order to develop a body of knowledge unique to learning by adults. It is pointed out that if sufficiently strong motivation could be provided for the professional to continue his education, more practitioners in *all* fields would try to stay abreast of new developments.

If each professional could take a self-administered test involving the use of a computer, his own shortcomings would be pointed out to him and his motivation to continue to study would be strengthened. This has actually been done by the American College of Physicians in its Medical Knowledge Self-Assessment Test.[10]

There is a very intriguing article entitled "Continued Education for What?" by Miller[11] of the University of Illinois. His provocative article is critical of the fact that most programs of continuing medical education have been conducted by the traditional methods of *teaching* rather than being based upon solid evidence about the way *adults learn*. The categorical content model (such as gastroenterology, hematology, cardiology) has been used, not the process model. Miller[11] criticizes educational programers offering gimmicks such as programed instruction, one or two-way television, live or taped, and movies, as if they were potent mechanisms for meeting the educational need. By what he considers inescapable evidence of failures, Miller[11] concludes that we have been educating for the wrong thing! The question in continuing education is not, as he puts it, the absolute worth of new knowledge but of relative priorities. He suggests that attention should be given to those things likely to be of great importance in the care of many rather than to those things which will benefit only a few. He cites the repeated, disheartening examples of the failure of education built upon the content model substantially to alter the behavior of practitioners. He finds that practitioners who learn more about topics do not *necessarily* transform this knowledge into *action*.

Miller[11] is constructive in his recommendation that we try the process model rather than the

† In New Jersey, those offered since 1957 at The Carrier Clinic are cited as examples.

** Number not avalable. There were also over 23,000 registrations for radio and television courses in 1965-1967.

categorical content one, adding that adult learning is not most efficiently achieved through systematic subject instruction. It is accomplished, instead, by involving learners in identifying problems and seeking ways to solve them. Learning emerges in a growing need to know — not in categorical bundles — and ultimately incorporates knowledge in a context that has meaning. Knowledge and performance are overlapping qualities but not identical dimensions. While the best performance is built upon sound information, the acquisition of sound information is not assurance that it will occur. Men learn what they want to learn.

The first step is not to tell them what they need to know, but help them to want what they need. It means involving participants in identifying their own educational needs in selecting the learning experiences most likely to help them meet those needs. Also it requires the assessment of whether they have learned what was intended — not merely determining whether they took part in the learning experience or whether they liked it. If the evidence demonstrates clearly that the desired learning did not occur, then another look must be taken at both the objective and the instructional methods to determine which requires change.

A method used as part of the Utah Pilot Study[6] could be a prime element of continuing medical education. Here, physicians were asked to record the clinical problems they encountered over a 48-hour period as well as a personal perception of their educational needs. This could well lead practitioners to a study of what they do, to an identification of their own educational deficits, to the establishment of realistic priorities for their own educational programs.

Miller[11] said that the practitioner-learner must progress steadily from listener to questioner to contributor. To help accomplish this progression the teacher must progress in the *opposite* direction until at last he becomes a thoughtful *listener*. Continuing education should mean continuing self-education — *not* continuing instruction. Furthermore, until the program directors recognize the need to know, it is unlikely that they will learn. Miller ends his article ironically by quoting Pogo. "We have met the enemy and they are us."

Carmichael,[12] has reported chronologically what has been developing in continuing education for psychiatrists. The American Psychiatric Association carried out a survey of existing continuing education courses for psychiatrists. Of the 1847 institutions which replied to the questionnaire, only 51 were found to be course sponsors — presenting a total of only 73 courses. Further documentation of the lack of activity in this area of education appeared in the American Medical Association's annual report of courses of continuing education for psychiatrists for 1967-68. Of the 333 courses listed in psychiatry, only 66 were for "specialists" (presumably including psychiatrists), while 48 were for physicians in general and 215 were open to generalists and specialists. This confirms the paucity of programs of continuing education for graduate psychiatrists and emphasized the urgent need for these courses and the importance of undertaking active work in encouraging and helping develop such programs. With the aid of a three-year grant from the National Institute of Mental Health, an office of continuing education for psychiatrists was established at the American Psychiatrics Association central office. Hugh T. Carmichael, M.D. was appointed director of the office. He is assisted by consultants. They have made two proposals: (1) That a psychiatric self-assessment program for psychiatrists be undertaken by the A.P.A. following the recent example of the American College of Physicians' Medical Knowledge Self-Assessment Program;[13] (2) that there be a survey of a representative A.P.A. District Branch to gather information about the practice habits of the members of the Branch and their expressed need for continuing education.

Carmichael has presented his plan for a self-assessment project. The individual member would purchase a kit and test his own skills

and knowledge so that only he would discover any areas in which he requires further education. It is anticipated that it will take a year to develop this proposed self-assessment test and that, hopefully, the proportion of members participating will eventually achieve the same ratio as the American College of Physicians — virtually 100 per cent: A plan like this might help forestall mandatory recertification and relicensure.

Basic educational research that requires highly specialized personnel will be supported by the National Institute of Mental Health through its continuing education branch and its new grants program. Some evaluation will probably be done by independent research groups. Comparative studies should be made of continuing education projects in different settings. Of special relevance to mental health service programs will be efforts to evaluate the extent to which continuing education increases the effectiveness of mental health services and reduces the incidence of disorders in the population being served.[14]

Conclusions

The American Psychiatric Association considers the self-assessment examination sufficiently important to disseminate the message to all District Branches urging their members to participate. Success of the program depends entirely upon the individual support of the individual members. It will require a good "public relations program" by the various District Branches.

The American Psychiatric Association has moved properly by taking the initiative in a program that holds promise of being assumed by the federal government. Hopefully, the Association will anticipate that move and thereby retain control.

This again, is a self-administered and self-assessment test so that *only* the individual member will know the result. If successful, the examination could be updated from year to year in order to enable the individual members to keep current with ongoing psychiatric changes.

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The Carrier Clinic

In this compact little article, a plastic surgeon suggests a safe and simple corrective procedure for unattractively protruding ears.

The Correction Of Protruding Ears*

Robby Meijer, M.D./East Orange

With a deformity of the nose as the possible exception, few parts of the human anatomy draw the attention of young and old as much as the protruding ear. The esthetic balance of the head and its appendages is easily disrupted by the deformity, however moderate the protrusion may be, since it also accentuates the size of the auricle. Ridicule often takes place which may have a lasting emotional effect on the victim. Unfortunately one can still hear common statements made such as; "you are a boy and do not have to be good-looking" or "good thing she is a girl and can wear her hair long." More and more, however, the futility of such statements is recognized and more individuals seek plastic surgical help to correct this noticeable deformity.

The three types of protruding ears most commonly seen are: (1) the moderate form of protrusion mostly due to an absence of the superior crus, causing the upper half of the auricle to stand out, (2) the so-called "lop ear" — the antihelix and crura are absent giving the whole auricle a cuplike appearance (see Figures I and II), (3) the unusually large ear which appears prominent even when only a minimal to moderate protrusion is actually present.

All three types can be satisfactorily corrected by removing an elliptical piece of post-auricular skin and weakening the cartilage along the lines of the proposed antihelix and superior crus. These structures are then constructed with the use of buried non-absorbable sutures. When and where indicated, slivers of cartilage are removed, care being taken not to cause sharp edged folds on the anterior surface of the ear. The skin is then closed and a bulky ear dressing applied.



Figure I — Pre-operative and post-operative views of patient with bilateral protruding ears

* From the Peer Group for Plastic Surgery, East Orange, N.J.

Figure 2A — Pre-operative and post-operative view of case with "lop" ears



Figure 2B — Close up pre-operative and post-operative view of ear showing detail of constructed anti helix and superior crus

Usually the surgery is done under general anesthesia requiring a two day hospital stay. For individuals over twelve to fourteen years old, local anesthesia is preferred. In adults, the procedure can often be carried out on an out-patient basis. Correction of protruding ears can be done at any age from five years up. There is no growth interference since around that time the auricle has already reached almost its adult size. Post-operative discomfort is minimal. The bulky dressing is worn for ten to fourteen days, followed by binding the ears nightly for two weeks.

Complications following an otoplasty are few. The earliest and most frequent one is bleeding which usually is controlled by changing the dressings. Infection is rare and prophylactic antibiotics are seldom used. Late recurrence of the protrusion does occur in a small proportion of cases necessitating a minor secondary correction.

Keloid formation of the post auricular scar is occasionally seen and of course difficult to treat, but its location makes this somewhat less cumbersome than keloid scars elsewhere on the face.

120 Halsted Street

less than 400 feet up and we were afraid it was going to land on the water. Then it went faster, rose quite steeply, and rode away. My fishing partner and I had had nothing to drink. I have never seen anything like it before or since."

"When my partner got home and told his wife, she wouldn't listen. She was so scared. Once when I went to their home for dinner, about three months later, I thought I'd mention it as a conversation piece, but she wouldn't let me talk about it (confirmed by author's interview of the gentleman, whose wife interfered in the telephone conversation). Shortly after the event I told my wife, a close friend (a neighbor of the author), and a man that I do business with. Strangely enough, another friend of mine, who was in the Catskills a hundred miles north of us, had noticed the thing the same day and at approximately the same time. I learned this one week after my experience.".

Mr. Collins' trustworthiness was attested by three people who have known him for many years: the author's neighbor, the author's father, and the friend who had been in the Catskills.

Although there were no log-book fishing records going back to 1958, the time of Mr. Collins' experience, interviews with Officer Clyde Conway of the Canistear Reservoir Police, Mr. Conway's wife, his daughter, and his two sons revealed several sightings of possible UFOs in that area in the past three years. No member of Officer Conway's immediate family has had any emotional or psychosomatic illness.

Case 3

Mrs. Carol Vander Plate, age 27, a high school graduate, licensed practical nurse and housewife, lives on a mountain top in Hardyston, New Jersey, where her husband owns and operates a radio station, WLVP. Her past life is free of any emotional or psychosomatic disease. It was on April 1, 1966 at 8:45 p.m., during a clear day, followed by moonlight: "Our two French poodles started barking and carrying on. They refused to obey and be quiet. They went crazy, running in circles and jumping over the furniture. There was a horrible rumbling sound. It sounded like a jet coming over and about to crash. I looked out the window and saw this thing sitting on top of the trees about four hundred feet from the house. I watched it for more than thirty seconds. It turned pink. It had three portholes that were black inside. The TV went off. When I turned on the porch light, the object seemed to turn off two big spotlights. It was white, then pink, then green; and then it took off like a streak of lightning. There was no trail of gaseous vapors. My husband announced it over 'open mike,' and from then until midnight four lines were steady with calls on each line from others who had seen it. It was fantastic. It was twice the size of a jet. Much bigger than my house. There were no effects on the trees; I checked that the next day. But we've had no robins or cardinals in this particular area since then." (See Figure 4.)

This experience was confirmed upon questioning Mr. Louis Vander Plate and five other observers from the town and neighboring area. Mrs. Vander Plate uses no alcohol or drugs. She became pregnant two months after this experience and delivered a healthy baby. She and her husband estimate they have seen and/or heard of similar sounds seven to ten times since this initial episode. Many of these accounts have been verified by others in the vicinity. One year after this particular sighting, Mrs. Vander Plate developed an allergy to nickel and her husband a severe reaction to "foam rubber — as in earphones — I turn beet red: it swells." The possible allergic condition was never related to the UFO experience, but it is included should other similar observations be made.

The Vander Plates' experience might have been related to another sighting that occurred over the near-by Oak Ridge Reservoir that same night at approximately the same time. The Newark *Evening News* reported "a white light with red revolving lights under it. It was hovering over the reservoir. It remained stationary and then darted across the clear night sky and halted tantalizingly in midair." Many people telephoned in to the Milton Township police headquarters.*

Case 4

Mrs. Estelle Conway, age 51, a business-school graduate, housewife, and postal subclerk of Highland Lakes, New Jersey, looked out of her dining room window one fall day in 1966, at 7:30 p.m. She noticed a large "orange ball" with a dark vermilion border, suspended, or hovering by itself, over a pond a quarter of a mile away from her home. At that distance, she estimated the size to be that of a chicken coop, and guessed that it would have been much larger than an automobile. She couldn't make out any other detail, but wondered if it was somebody's auto headlights shining on the trees in the woods. The lake is 1,100 feet above sea level and the hill about 1,400 feet; therefore, the object was estimated to be less than 300 feet above the water. The object didn't change color or shape; it had no sound; and it did not influence the radio or electrical devices in the home. The object was some 700 feet from high-tension wires.

Mrs. Conway was embarrassed because people would not believe her when she told them what she saw. She does not use drugs, and only occasionally does she have a cocktail. She told her husband and other members of her family about the episode. The husband told a neighbor, who was a state policeman. Her experience was confirmed on telephone interview of the trooper. Mrs. Conway had no past history of any emotional disorder or other illness. When she looked for the object, approximately fifteen minutes after first seeing it, it was no longer there. (See Figure 3.)

At the same time of Mrs. Conway's experience, Mr.

* As a clinical check on the veracity of the witnesses, the author first learned of this event from a nineteen-year-old boy who lives near Oak Ridge Reservoir. He, with his teen-age sister and brother, had seen UFOs at close range over the reservoir on two previous occasions.

Guy F. Adams, age 46, an electrical engineer, of Glenwood, N.J., while driving on the road and approaching the Conway's home, had the "surprise of my life" when he noted, "a big, opalescent-like neon-green ball, 500 to 600 yards out. Not on a ballistic course, but gliding — not enough speed to maintain flight itself. It slowly went across the road — tree-top to tree-top — for an estimated six to eight seconds. It was a ball, straight ahead, right across the road. I have good depth perception. It was aquamarine in opalescence. However, it kept perfect geometry all the time. (It did not shimmer.) It passed over the mountaintop store. There were no effects in the car. If it had been a ballistic trajectory, it would have had to crash into the lake (in the valley).

"I stopped the car near the store and jumped out to see. I went down to the point where it had crossed and where I thought it should have crashed. But it had by then disappeared. There was still good light out. The sun was setting. Obviously the light of the object had to be greater than the light of the sun to be seen. I was very excited and wondered how could a thing appear to have no weight and "fly" across the road at such a very low speed. It traveled in an east-to-west direction. The estimated size was 50 to 55 feet across — approximately the size of a dime on the windshield — roughly half the size of a B-17 bomber. I was a U.S. Army Air Force gunner in World War II, and saw active duty. I'm a student pilot and have designed beacons for space probes, and such, but have never come across anything like this in my life."

Mr. Adams told his wife and a state trooper at the time. The locale of the Conway-Adams sighting is only a few miles from radio station WLVP-FM. Aside from two weeks of a "nervous breakdown" in 1944 (when in the Service) he has had excellent health. Following the "breakdown" he returned to active duty in the Air Force, and served six more years as a career man. He does not use drugs unless prescribed and has had excellent emotional health.

The Newark *Evening News* contained several articles of similar sightings in northern New Jersey during the fall of 1966.

Case 5

Frank Scanlon, age 56, has been a United Parcel Service driver for 37 years. He is a union steward. He has had a northern New Jersey route for twelve years. As a U.S. Air Force veteran of World War II (Fifth Air Force, ground crew in Japan) he is familiar with aircraft. He is respected by his boss and fellow employees. He neither smokes nor drinks. He enjoys excellent health. Psychiatric interview revealed no evidence of emotional illness. Although he could not recall the exact date of his alleged UFO experience, at that time he told his immediate family, his boss, many fellow workers, and several other people. Interviews with his wife, two of his children, and four other people, including a police officer, confirmed Scanlon's excellent reputation and his report of the experience shortly after it happened. It was stressed how excited and frightened he was.

"It was November, 1967. It was bare and there were no leaves on the trees. It was on Rudeville Road on the way to Great Gorge (within a mile of the Vander Plates' radio station) at twelve noon, on a clear day. I went to the back of the truck and heard this terrific pounding noise. As I went to the front, I stepped away from the truck as I thought the noise was from the well digger across the street. But he had dived into the hole. At tree height, I saw a cylindrical object, like a dirigible, more than twice the size of the von Hindenberg. It was big enough for several Mack trucks to get into it. It had no cabins or propellers, no markings of any kind. It was a duller grey than aluminum. There was no smoke, heat, or exhaust. There was no effect on my truck motor. It was unbelievable. It had roundish windows that looked black inside. There was no reflection on them. It took off with such force toward Newton that it disappeared in an estimated two minutes.

I never saw such a burst of speed after hovering. I was amazed. There were no exhaust fumes. I wondered what could defy gravity and hover there. It was gigantic." (See Figure 5.)

Comment

Single-witness UFO examples, and, in some cases, lack of specific dates, have drawbacks. However, the favorable close-range circumstances support the validity of the experiences. The witnesses were healthy and trustworthy. They had no gross defects of vision or hearing. They had ample time to observe the UFOs. There was nothing suggestive of malobservations, behavioral aberrations, mass hypnosis, contrived posthypnotic suggestion, or fraud. The unique characteristics of the episodes and the backgrounds of the witnesses excluded such explanations as satellites, airplanes, balloons, helicopters, or birds, although very atypical ball lightning could have been a possibility for Case 4. There was nothing suggestive of a parapsychologic explanation in any of the examples. Most of the witnesses were frightened and had a vivid memory of their unique experiences. In Case 3, it was possible to see how easily mass panic could have developed. The physician, by having an awareness of UFOs, can help to avert mass hysteria.

Five hidden reports of UFOs from a relatively circumscribed area in northern New Jersey are but a small sample of the thousands of documented accounts from all over the world. UFOs indeed, do seem to be real. Physicians are in an excellent position to uncover "hidden reports" of UFOs and help to establish

the reliability of the witnesses. By study of the possible emotional and physiologic effects of the UFOs, and of the witnesses themselves, the physician can go beyond merely establishing the event and contribute to the more meaningful questions of (1) what UFOs are (2) where they come from, and (3) what is their purpose.

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Immunization By Inhalation

The best way to be vaccinated against tuberculosis is with BCG vaccine; and the best way to take the vaccine is by breathing it. So says Dr. Sol Roy Rosenthal, professor of preventive medicine and director of the Institute for Tuberculosis Research at the University of Illinois.

Dr. Rosenthal believes that people should be immunized against diseases in the same way in which they would contract it. Tuberculosis is spread by pathogenic bacteria which are inhaled; therefore, the BCG vaccine should be inhaled, rather than injected.

To put these bacteria into the air in a dense mist, Dr. Rosenthal recently turned to a new ultrasonic nebulizer. On modern electronics principles, this machine uses ultrasonic energy to create man-made fog. The fog is composed of extremely small water droplets, which means it can penetrate to the smallest, deepest, pulmonary structures. This is just the sort of vehicle which Dr. Rosenthal needs to carry the BCG clones into the body.

The rate of success of immunization is directly related to the amount of dose, Dr. Rosenthal found. To be vaccinated with the ultrasonic nebulizer, his subjects simply sit in a room for 45 minutes. For 30 minutes they breathe the dense BCG-laden fog. During the next 14 minutes they wait for the fog to be removed by a complete air change.

As many as 15 people have been vaccinated in a room at one time with this method. He has processed 23 school children and 10 medical students with ultrasonic BCG fog. Using a tuberculin skin test, he has been able to find some degree of immunity in all of them. Now Dr. Rosenthal looks forward to an ultrasonic immunization console which could vaccinate entire classes at once.

Urologic surgery in children does present special anesthesia problems, which are here reviewed.

Anesthesia Problems Associated With Obstructed Uropathy In Children*

Herbert Rackow, M.D./Whitestone, N. Y.

Almost nineteen years ago, there was a symposium on anesthesia in pediatric urology. The report[1] presented by the anesthesiologist concerned itself mainly with the head end of the child, and had little to do with the urology end. Two sentences from that paper will make this clear. "There is no anesthesia that is singularly specific for uropediatric cases," and "the requirements of the urologist for his pediatric patient do not differ materially from those of other surgeons concerned with children." These statements still hold true today despite a vast increase in the literature of pediatric anesthesia. For example, nineteen years ago, there was one textbook[2] on pediatric anesthesia. Today, there are four[3, 4, 5]. Nevertheless, I have been able to find fewer than a half dozen references specific for today's symposium.

Churchill-Davidson, Way, and deJong[3] have a report on muscle relaxants and renal excretion suggesting that d-tubocurarine but not gallamine is handled normally by the body when there is ab ent renal function. This study was in adults who had bilateral nephrectomies or explorations of renal tissue. The patients receiving d-tubocurarine were treated with neostigimine postoperatively, recovered completely, and had no evidence of muscle paralysis. Those patients receiving gallamine were also given anticholinesterase treatment but three out of five patients had recurring muscular weakness lasting a few days and required hemodialysis to restore normal neuromuscular transmission. This would suggest that patients with impaired renal function should be given d-tubocurarine rather than gallamine.

Other drugs commonly used in anesthesia are excreted by the kidneys. Goodman and Gillman[7] point out that most of an oral dose of barbital and 25 per cent of phenobarbital is excreted in the urine. When renal function is impaired, these sedatives are poorly excreted and may cause severe depression. Pentobarbital, secobarbital, and pentothal are metabolized in the liver. These should be used rather than barbital or phenobarbital. In severe renal disease, it may be safer to give any barbiturates by the intravenous route so that the response may be exactly titrated with small doses, rather than to give one intra-muscular injection of an average dose. Rectal administration would be least desirable.

Although we have a busy pediatric urology service at Babies Hospital in the Columbia-Presbyterian Medical Center, we rarely see children with such serious renal impairment that complications of this type might be expected. Nevertheless, if alternative drugs are available, I would certainly avoid those which are excreted in the urine in patients with *any* degree of impaired renal function.

The problem of halothane liver toxicity should be mentioned. Halothane has many good properties and its use has undoubtedly

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* Read before the Sections on Anesthesiology, Pediatrics, and Urology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969. This work was supported by NIH grant GM-09069-07.

saved many lives. Yet, there is associated with it, as well as with other anesthetics, a fatal hepatitis with an incidence of about one in 10,000 anesthesias.[8, 9, 10] This complication seems to be much less frequent in children than in adults, although the incidence is not known in children. It may be that there are simply fewer children anesthetized than adults. A second point is that there seems to be a greater risk in patients who have previously been given halothane anesthesia and showed an unexplained fever or enlarged liver or jaundice in the postoperative course. Patients with this history who are subsequently given a second halothane anesthesia make up a proportion of the fatal hepatitis cases[11]. Many of the patients we are here talking about have multiple urologic procedures during which multiple exposures to halothane may occur. Cystoscopies and retrograde pyelograms are important diagnostic procedures which precede definitive surgery in these children. Halothane is a non-explosive anesthetic and therefore is often chosen because of x-ray requirements. It may set the stage for hepatitis if, for the next surgical procedure, halothane is again chosen. The advantages of halothane for a long surgical procedure make many anesthesiologists reluctant to give it up, particularly for such a short procedure as cystoscopy. I would prefer to use pentothal plus nitrous oxide for the cystoscopy and save the halothane for the surgery. When it is at all possible (and I recognize that perhaps in most cases it may *not* be possible) I would like to see diagnostic cystoscopy scheduled in the operating room, to be followed by surgery. This has the added advantage of avoiding one anesthesia regardless of what anesthetic is used.

If an obstructive uropathy is complicated by renal impairment, anemia may develop. There is good indirect evidence[12] that an anemic patient has reduced oxygen stores, reduced compensatory mechanisms and reduced oxygen transport. The anemic patient will develop tissue hypoxia faster than the non-anemic patient in the event of impaired circulation or impaired respiration. The infant and the small child are especially susceptible because of their high oxygen requirements, almost twice that of the adult. If the anemia is present and surgery cannot be postponed (and if little blood loss is anticipated during surgery), transfusion may not be justified. The incidence of post transfusion hepatitis may be as high as 4 per cent. The case fatality is about 11 per cent. Overall fatality[13, 14] may be up to one in two hundred. The anesthesia mortality is less than that, perhaps one per thousand in infants[15]. If the anemia is severe or if the surgery is major, transfusion is indicated either preoperatively or as soon as anesthesia is started. Lung stores of oxygen may be increased by using a high oxygen concentration in the anesthetic mixture.

Sometimes the surgical position of the child that gives optimal surgical exposure is such that it interferes with respiration. This is especially so when the child is in a lateral decubitus and the kidney bridge is raised. The respiratory inefficiency may be partly compensated for by endotracheal intubation and assisted or controlled respirations. We do not hesitate to use an endotracheal tube in infants and children, particularly in the absence of an upper respiratory infection. There are complications due to intubation but there are also complications resulting from not intubating. While we do not have evidence, we think that these latter complications in the long run, are the more serious.[12]

McDonald and Good[17] have written about anesthesia for voiding cystography in children. The problem is having the child urinate during the process of recording bladder performance. The belladonna drugs, scopolamine and atropine, decrease bladder tone and premedication was either meperidine or pentobarbital alone. Halothane anesthesia was used. Under anesthesia, radioopaque solution was instilled into the bladder to 30 centimeters of water pressure. A cystogram was taken and the child allowed to recover from anesthesia. Of those children given pentobarbital 23 of 24 voided, while only 14 of 19 given meperidine voided. This is not unexpected because meperidine has weak atropine-like properties.

Premedication is a special problem in pedi-

atric urology due to the multiple surgical procedures which many of these patients go through. Orthopedic and plastic surgery present identical problems. After having been through many operations, some of these children seem to be resistant to average doses of commonly used sedatives. Many will come to the operating room alert and terrified after having received enough secobarbital and meperidine to put an adult to sleep. Then as soon as the child is anesthetized, he suddenly becomes severely depressed and breathes very poorly. Somewhere along the many surgical experiences of such a child, something, either a traumatic anesthesia induction, or a painful postoperative course, or consistent periods of postoperative vomiting after each operation, resulted in an emotionally sensitized child. Sometimes, such a child comes to the operating room retching and frightened. In a case like this, the child should be lightly rather than heavily medicated and intravenous pentothal used for induction. It may also be helpful to use an endotracheal tube and to leave it in place during recovery until the child is awake, because vomiting on emergence is also frequent in these children.

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Acute Traumatic Rupture Of The Thoracic Aorta:

Report Of A Case With Rupture Of The Innominate Artery*

Victor D'Ambrosio, M.D./Murray Hill

With the accelerating speed of modern transportation the emergency rooms of our hospitals have seen an increasing number of cases of traumatic rupture of the thoracic aorta. We should consider this possibility whenever called upon to care for a severely ill victim of a traffic accident. If the diagnosis is made early enough the patient's life may be saved.

The patient may present either of two syndromes:

(1) The exsanguinating form, where the mortality rate is about 85 per cent, or

(2) A milder form with a mortality rate of about 15 per cent. This is true provided the diagnosis is established promptly.[2] From the standpoint of prognosis, traumatic rupture of the thoracic aorta may be divided into the following categories:

(A) Acute traumatic rupture with severe exsanguination. The mediastinum is widened, hemorrhage is extending into one of the pleural cavities. Chest x-ray can reveal this. These patients die almost immediately.

(B) Chronic traumatic rupture. Here, patients who survive the acute rupture, are divided into two subgroups:

1. In which the hemorrhage is contained in a hematoma.[3] The patient may die of delayed rupture of this hematoma within the first few weeks after injury;

2. In which the patient survives but develops a false aneurysm. This can remain stable for months or years. In 1960 Malm and Deterling[1] reported a case of successful resection of traumatic aneurysm three months after the injury.

The following case is illustrative of the diagnostic and therapeutic problem:

A 63-year old woman came into the Newark City Hospital with multiple fractures of the lower extremities and spine. She had been hit by a motorcycle. Upon admission she appeared confused, complaining of pain in both legs, in her right arm, along the cervical spine, and between the scapulas. She had been hypertensive for ten years, and had had a hysterectomy at the age of 33. Blood pressure was 180/100. She showed mild contusions of soft tissue. Moist rales were present in the base of both lungs. The heart had normal sinus rhythm; there was a grade I systolic murmur over the base of the precordium. Abdomen was soft. The liver was one finger below the right costal margin.

Bronchoscopic examination showed that the right middle lobe bronchi were clear. Washings were negative for tumor cells. X-rays on admission revealed widening of the aortic shadow and a right parahilic shadow, thought to be a mediastinal tumor or pneumonia, occupying the right middle lobe and medial basal segment. However, findings compatible with segmental bronchial obstruction were not revealed by bronchoscopy and bronchogram, which showed good arborization of bronchi of lower and middle lobes.

Sixty days after admission, x-rays showed disappearance of the mediastinal shadow and widening of the superior mediastinum; the ascending aorta appeared wider, more prominent, and its lateral margin was straightened.

The diagnosis of an aneurysm of the ascending aorta was considered at this time, but an attempt at doing an aortogram failed to visualize the arch of the aorta; instead, it revealed an obstruction of the origin of the innominate artery and diffuse uniform thickening of the wall, compatible with a dissection of the ascending aorta extending into the innominate artery.

This represents a healed traumatic rupture of the aorta. We report it because the formation of a dissecting aneurysm produced obstruction of the innominate artery, which this patient had survived[3] and because of the fact that clinical experience with such problems is so limited. Also we have here an association of closed multiple chest injuries with the rupture of the thoracic aorta *without* concomi-

* From the Surgical Department of Overlook Hospital, Summit, New Jersey.

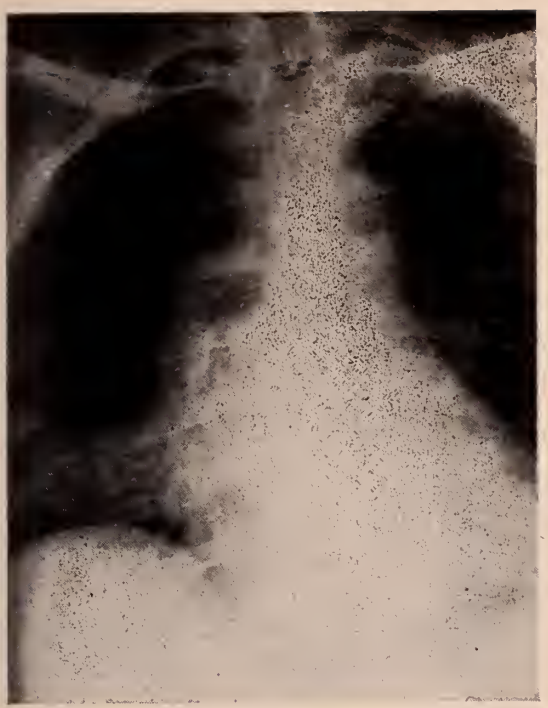


Figure 1. Widening of the mediastinum. Bronchoscopy and bronchogram revealed normal bronchial tree and no evidence of lung pathology.

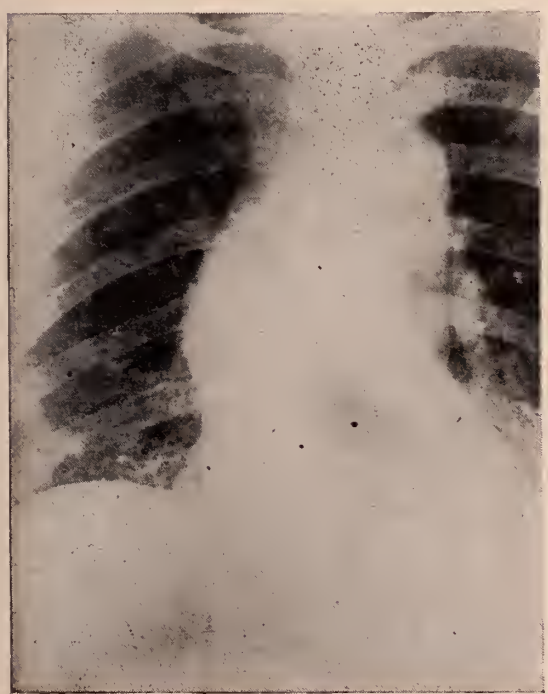


Figure 2. Reduction of mediastinal shadow, but widening of mediastinum still evident. The ascending aorta appears wider, more prominent with straightening of its lateral border. We consider this as evidence of dissection and aneurysm, secondary to traumatic chest injuries.

tant rib fracture. Moreover, as this patient with hypertension was in an upright position when hit by the motorcycle, this case fits the criteria expressed in the mechanism of dissection exposed below.

Rupture of the aorta with hematoma may be contained by the overlying visceral pericardium or lung, as it was found by the pathologist of Overlook Hospital in one case.

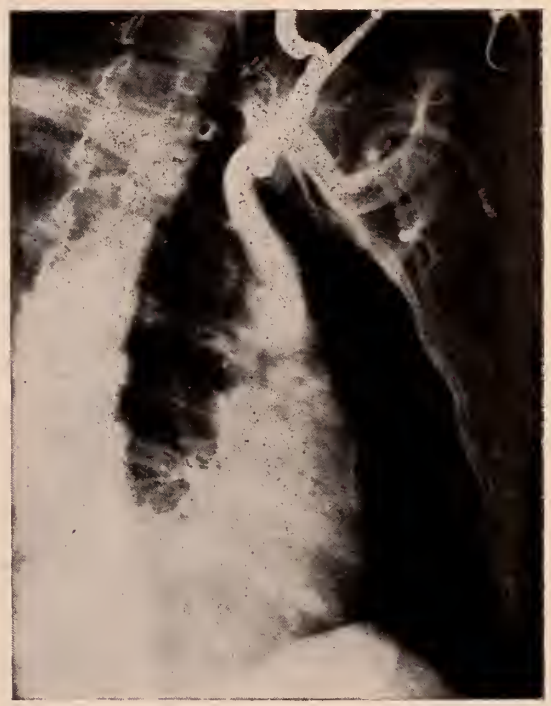


Figure 3. Attempted aortogram failed to visualize the aortic arch. Obstruction and diffuse thickening of the wall of the innominate artery is obvious. This finding is compatible with traumatic dissection of the ascending aorta extending into the origin of the innominate artery.

The hematoma may organize and give origin to so-called "false aneurysm." In such case, the outcome is not fatal. When the rupture of the aorta takes place in a location that does not confine the blood, a hematoma is not formed. This second chain of events may give rise to fatal hemorrhage. Cases have been reported[7] at post mortem in which the incomplete aneurysm involved the aortic arch at the base of the innominate artery with obstruction of the latter.

Etiology

Traumatic thoracic aneurysms are caused in most cases by automobile accidents. Uncommon causes are a fall from a height, direct crushing blows to the chest, and a sudden rise in intravascular pressure. The horizontal deceleration force is thought to be the basic cause of aortic rupture in automobile accidents. The traumata include:

(1) Fracture of the first rib is often associated with dissecting of aorta.

(2) Contusion of chest.

(3) Fracture of the skull and extremities with contusion of chest and abdomen.

(4) Hypertension.

(5) Pregnancy.

(6) Emotional stress resulting in hypertension.

The mechanism of traumatic dissection of the aorta includes the following considerations:

(1) Compression of chest during full inspiration.

(2) When heart and aorta are bound between inflated lungs.

(3) Trauma is more accelerated when the heart is in diastole.

(4) Closure of the heart valve produces traction on the aortic wall.

(5) Incomplete aortic rupture as first stage of dissecting aneurysm.

Aortic dissection may occur just above the aortic valve in 55 to 75 per cent of the cases.[6] Less commonly, it is found just below the attachment of ductus arteriosus. It may be noted at the origin of the intercostal arteries. Experimental rupture of the intima has been demonstrated at the first two sites.

Diagnosis

The clinical history, the mechanism of trauma, and the physical findings coupled with chest x-rays are usually sufficient for the diagnosis,[1] however physicians caring for patients who have undergone severe general trauma to the chest must be aware of progressive shock or heart failure without obvious cause. The loss (or diminution) of peripheral pulse and blood pressure or discrepancies of them in the four extremities, the development of increasing venous pressure, or evidence of superior vena cava obstruction, the presence of widening of the mediastinum on routine chest x-rays are signs of injuries to the heart and the great vessels.

Roentgenographic examination of the thorax should be done in patients less vitally ill. Aside from the presence of mediastinal or pleural effusion, and the widening of the mediastinum, there are specific signs which the radiologist looks for in the aortic wall. This wall usually measures 2 to 3 millimeters in thickness. Measuring up to 10 millimeters is suggestive. And a widening to over 10 millimeters is diagnostic of intramural hematoma.

The value of roentgenograms in confirming diagnosis of dissection of the aorta, has been exemplified by widening and radiolucence of arch and descending thoracic aorta. Also significant is widening supracardiac shadow of the entire thoracic aorta or of a segment of it.

Extravasation of blood into mediastinum will accentuate the aortic shadow. Dissection of a major branch of the aorta when demonstrable is an important diagnostic feature.

The formation of a hematoma within the wall thickens it and it appears more radiolucent than the dense true lumen of the aorta. Also meaningful is the double-barreled appearance of the aorta.

Sectional laminograms and aortograms may be helpful.[4]

Conclusion

We have reported a case of traumatic dissection of the ascending aorta with extension and obstruction of the innominate artery which the patient survived. The importance of early diagnosis of such an injury is stressed. Note is made of the increasing frequency of aortic dissection associated with multiple trauma resulting from the ever growing traffic accidents.

The surgeon must be aware of the possibility of such catastrophies not only in patients who have suffered immediate or recent trauma, but also in patients with hypertension or during pregnancy. Remember that severe injury to the cardiovascular system can be present even when the patient does not appear severely ill. And in some patients like the aged, the hypertensive, and those with Marfan's syndrome, minor trauma can result in serious injuries.

Aortograms, including angiocardiogram, may be indicated as emergency procedure.

More use should be made in our emergency rooms of continuous monitoring of the electrocardiogram. The central venous pressure and the recording of peripheral pulses and blood pressures in all the extremities should be carried out on all patients in whom serious injuries to the cardiovascular system are suspected. Traumatic dissection of the aorta may be a true immediate emergency. In these cases, successful treatment may ultimately rest on how well equipped the modern community hospital is.

Suspicion is half of the diagnosis. Some of the recent reports seem to indicate that treatment of hypertension would result in control of the acute dissection. However, the surgeon and the operating room must be ready for such an emergency, because in some cases surgery, with the help of the heart-lung machine may be the decisive factor between life and death.

The National Safety Council has estimated that this year there will be approximately 9,500,000 accidents causing 93,000 deaths. In 66 per cent of victims of multiple injuries, two or more body areas are involved. On the basis of these facts we concur with those who feel that the heart-lung machine for pulmonary by-pass is essential for the total care of the patient with cardiovascular injuries.

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The community hospital, willing, able, and properly staffed, can operate a modern hemodialysis unit.

Hemodialysis At A Community Hospital*

A Preliminary Survey

John F. Mele, M.D./Neptune

The first artificial kidney device was built by Dr. Willem J. Kolff in the Netherlands in 1944. For many years only a few hospitals purchased the machine. The equipment was expensive and long term treatment was so costly in terms of personnel needed, that it did not seem feasible. The hospitals that did obtain the machine used it only several times a year for patients with acute renal failure, where a few sessions on the device would give their own kidneys a rest and help them recover.

The University Hospital in Seattle, Washington, in 1960, was the first to initiate hemodialysis for the long term treatment of chronic renal failure. This was accomplished by Scribner, Buri, Caner, Hagstrom and Burnell.[1]

However, chronic hemodialysis was still impractical until a number of technical improvements were developed to connect and disconnect the arterial and venous circulations of the patient to the artificial kidney without repeated surgical procedures. In 1960, Quinton, Dillard, and Scribner developed permanent arterial and venous cannulation; thus permitting repeated intermittent hemodialysis.[2] In this way, when the arterial and venous cannulae are not in use; they are connected with a "shunt" creating an arteriovenous fistula functioning outside the body.

Gradually, the experiences of other centers using chronic hemodialysis were reported[3,4] and, at present, leave no doubt that this now has a definite place in the treatment of acute and chronic renal failure. In this paper, we describe the technic used at Jersey Shore Medical Center-Fitkin Hospital and report some of our experiences during the past eight months.

Twenty-three patients with ages ranging from 20 to 81 years of age were treated at Jersey Shore Medical Center by hemodialysis. Ten had chronic uremia, seven had acute uremia, and six had acute poisoning. In the latter, the presence of hemodialysis facilities were of life-saving importance. The chronic uremic patients had indwelling "Silastic" and the teflon cannulae inserted, according to the method of Ramirez, in the less dominant side.[5] All cannulae were inserted in the operating room, by one of the two surgeons of the dialysis team.

The acute uremics and acute poisonings had a McIntosh catheter inserted into the greater saphenous vein according to the method of McIntosh.[6] The catheter is 24½ inches long; one lumen runs the full length and terminates at the distal tip. The second lumen terminates at 7½ inches from the distal tip. Both lumens have a bore of 2.3 millimeters and have a more than adequate fluid capacity. The catheter is placed finally in the inferior vena cava and causes no undue harm if left in place for 36 to 48 hours.

All hemodialyses were performed with the twin coil kidney. In the chronic uremics the dialyses were initially supervised by a physician present in the room. However, trained

* This report is from the Jersey Shore Medical Center where Dr. Mele is Director of the Dialysis Unit.

nurses eventually assumed this role and the physician acted only in a supervisory capacity. Nurses were able to initiate and terminate dialyses themselves. The duration and frequency of dialyses were pre-determined by the physician and were dependent upon each individual's needs.

In the acute uremics and acute poisonings, a physician was at all times present to evaluate any clinical deterioration; prescribing, if necessary, other therapeutic measures for circulatory and respiratory support.

The dialyzer was primed with heparinized normal saline; and again at the conclusion of dialysis, normal saline was rinsed through the coil to return the blood to the patient. Patients were heparinized with a constant drip of aqueous heparin during the procedure unless bleeding was excessive or suspected; therefore certain adjustments were made accordingly. Laboratory tests were obtained when indicated.

Chronic uremics were maintained on a diet that was variable, at times restricting their sodium, potassium and protein intake. Fluid intake was restricted and varied according to each individual's need. Medications such as antihypertensives, aluminum hydroxide gel, iron and multi-vitamins were prescribed if a need arose.

Results

The patients' data appear in tables 1, 2 and 3.

Ten patients were accepted for our chronic hemodialysis program and were maintained for a total of 36 months, averaging 3.6 months per patient, with a range of one to seven months. During these eight months, a total of 298 hemodialyses were done. Of the ten patients, five are alive giving an average of 4.2 months per patient. Seven patients were dialyzed for acute uremia; of these seven, four are alive. All six acute poison patients are alive; giving a total of fifteen patients still alive and eight patients dead and a general survival rate of 65 per cent.

Chronic Uremia

In the past 25 years, treatment of patients with uremia has changed drastically. In the early days of chronic hemodialysis, patients underwent dialysis every fifth to seventh day for periods of 20 to 24 hours.[1,7,8] Most of them remained symptomatic.[7] With better understanding of the pathophysiology of the uremic syndrome, it became apparent that more frequent dialyses were necessary and contributed significantly to the well-being of the patient. There were also further improvements in survival rates in patients with chronic renal failure.

Need for dialysis varies with each individual. Frequency and duration of dialysis should be sufficient to maintain each patient in such a state of health that he may carry on his daily functions. Ideally, all the symptoms of uremia should be absent or held to a minimum. Actually, a major problem in a chromic hemodialysis program is the selection of patients. There are more candidates than can be properly cared for with existing facilities. The prime criteria for patient selection were as follows:

1. Emotional stability.
2. Ability to adapt and cooperate.
3. Absence of a second disease which would impair general health.
4. No cardiovascular complications due to severe hypertension (cardiac insufficiency, coronary thrombosis, cerebral vascular accidents).
5. Age limit: 55 years.

The criteria for medical acceptability are variable and indistinct. Age, which at first was thought to be the all important factor, is deemed of less importance at present. Not only have patients in their sixties done well, frequently becoming totally rehabilitated, but also in certain instances,[14] children as young as twelve years old have had very gratifying results.

Hypertension, associated with severe hypertensive cardiovascular disease, has been in the past considered sufficient reason for a patient's

rejection.[9,13] These patients are more difficult to manage and take more time to rehabilitate. But with proper controlled long term intermittent hemodialysis, including bilateral nephrectomy in a few selected instances,[9] hypertension and hypertensive cardiovascular disease can be brought under control. We have had experience with several of such patients.

The combination of diabetes mellitus with chronic renal failure frequently precludes patients from dialysis therapy regardless of the severity of the diabetes. One patient under our care, a 69 year old male, may have been rejected from a chronic dialysis program elsewhere because of a history of diabetes mellitus and advancing age. However, since the inception of his dialytic therapy 4 months ago, he has done extremely well and has returned to his former job and has experienced no difficulties.[10] Each patient should be considered on an individual basis rather than through the formulation of broad generalities. The burden of proof in the assessment of medical eligibility lies with the physician. Prime consideration should be whether a patient has the ability to adapt to his disease and the will to cooperate. Those who cannot or will not cooperate will not do well.[11]

At times, social or financial hardships exist which make cooperation difficult. The relationship which exists between patients and their families is extremely important. Support for the patient must come from the family.

In our chronic hemodialysis program all these factors are investigated fully by the aid of a psychiatrist and social worker prior to starting a patient on chronic hemodialysis. Motivation is an important factor. Patients who have a vigorous interest in rehabilitation and demonstrate a determination to return to their previous role in society are frequently able to do so, while those who are unable to accept their disease and constantly bemoan their fate, more often than not remain incapacitated.

Yet, in some, despite these handicaps, a significant change in attitude can be brought about through understanding, firmness, and perseverance while human nature dictates extension of sympathy to the sick, it is not sympathy that these patients require, rather it is a foundation of resiliency which enables them to rebound anew from each setback with a firm determination to succeed.

Acute Uremia

Hemodialysis has not improved the general survival rate of patients with acute uremia by more than 50 per cent. Good conservative management is still a fundamental part of the treatment of acute renal failure. It may be supplemented, but can never be replaced, by hemodialysis.[12] In our series of seven patients, four are still alive and doing well, but three are dead. Two of the three deaths were in patients over 65 years of age, emphasizing that the management of older patients is more difficult and has a higher morbidity and mortality rate.[10] All three did show improvement in their uremic symptoms. Two patients died of acute myocardial infarction and one in respiratory failure.

Prime aim of treatment is to minimize the metabolic derangements in acute renal failure. During the oliguric phase, where most patients are lost, the main hazards are:

1. Cardiac arrhythmias or arrest related to electrolyte imbalance.

2. Circulatory overload leading to acute pulmonary edema.

3. Water intoxication leading to seizures or vomiting which may persist and contribute to aspiration of gastric contents, bronchial obstruction, and pneumonia.

4. Depressed sensorium.

During the diuretic phase, there is decreased resistance to infection and septicemia may occur and, at present, is one of the main causes of death.

Under these circumstances dialysis will extend the capability of the clinical management to control body fluid volume and composition and prevent or reverse uremic symptoms. However, dialysis should be performed at the earliest signs of clinical deterioration. The trend in recent years has been toward in-

TABLE I
Chronic Uremics

Case No.	*Age & Sex*	*Disease*	*Period of Dialysis*	*Status*
1	67 M	Chronic Pyelonephritis	7 months	Dead
2	56 F	Bilateral Polycystic Kidney	7 months	Dead
3	54 M	Chronic Pyelonephritis	6 months	Dead
4	43 M	Chronic Pyelonephritis	2 months	Dead
5	38 F	Chronic Glomerulonephritis	7 months	Alive
6	70 M	Chronic Pyelonephritis	1 month	Dead
7	69 M	Chronic Pyelonephritis Diabetes Mellitus	4 months	Alive
8	45 F	Chronic Pyelonephritis	2 months	Alive
9	52 F	Bilateral Polycystic Kidney	1 month	Alive
10	48 M	Glomerular Sclerosis — Diabetes Mellitus	1 month	Alive

TABLE 2
Acute Uremics

Case No.	*Age & Sex*	*Diagnosis*	*Number of Dialysis*	*Status*
1	81 F	Acute Renal Failure due to obstructive uropathy, dehydration, electrolyte imbalance.	3	Died
2	51 F	Acute Renal Failure due to post-operative electrolyte imbalance and shock.	1	Alive
3	60 F	Acute Renal Failure due to electrolyte imbalance.	3	Alive
4	66 M	Acute Renal Failure due to post-operative prostatectomy	6	Alive
5	43 M	Acute Renal Failure. Pancreatitis. Electrolyte imbalance.	1	Died
6	72 F	Acute Renal Failure due to obstructive uropathy.	7	Alive
7	66 F	Acute Renal Failure due to obstructive uropathy and electrolyte imbalance.	1	Died

creasing use of dialysis in a growing number of mild chemical disorders so that severe clinical symtomatology and chemical abnormalities due to renal failure can be eliminated and further reduce the mortality. In those centers[12] using "preventive" dialysis[15] the mortality rate has been reduced to 35 per cent. But the mortality in any large unselected group of patients with acute renal failure still will depend not only on the vigor with which dialysis is applied but also on the age of the patients and the severity and reversibility of the primary disease.[16]

Table 3 summarizes our experience with six patients who were dialyzed for acute poisoning. All the poisonings occurred during suicide attempts. Poisoning by sedative-hypnotic drugs must be distinguished from that due to intracranial, metabolic, or electrolyte disorders as well as that due to anaphylaxis and septicemia. Overuse of alcohol, ataractics, bromides, and heavy metals has to be considered.

A tentative diagnosis can be often obtained by questioning the patient's family or friends;

TABLE 3

Cases Of Acute Poisoning
(All Survived)

Case No.	*Age & Sex*	*Medication Type, Amount, Total Doses*	*Duration of Dialysis*
1	20 F	Sodium Secobarbital 100 mg., 28 capsules 2.8 grams	4 hours
2	31 F	Meprobamate 400 mg. 40-60 tabs. 16-20 grams	4 hours
3	40 F	Chloral Hydrate 500 mg. 30 capsules 15 grams	3 hours
4	34 F	Sodium Secobarbital 100 mg. 32 capsules 3.2 grams	4 hours
5	28 F	Amitriptyline HCl (Elavil)® 25 mg. 25 tabs. .625 grams Propoxyphene hydrochloride phenacetin and caffeine (Darvon Compound — 65) 65 mg. 20-30 capsules 1.3 — 1.95 grams	7 hours
6	25 F	Trifluoperazine (Stelazine)® 10 mg. 40 tablets .4 grams Amitriptyline HCl (Elavil)® 50 mg. 40 tablets 2 grams	8 hours

finding an empty bottle or information regarding previous illnesses, trauma, or the use of drugs. The physical examination should emphasize vital signs, signs of trauma, and neurologic abnormalities. Odor of the breath suggests alcohol intoxication or acidosis of diabetes mellitus.

If sedative-hypnotic poisoning is suspected, treatment should be instituted immediately. Seek to restore ventilation by a pharyngeal airway or endotracheal tube. Respiratory assistance, if necessary, can be administered *via* a respirator. Frank shock is treated immediately with plasma expanders, sympathomimetics and corticosteroids.

TABLE 4

Depth Of Depression Resulting From Sedative-Hypnotic Poisoning

Class 0	Asleep but can be aroused
Class 1	Comatose but will withdraw from painful stimuli
Class 2	Will not withdraw from painful stimuli but has no significant respiratory or circulatory depression.
Class 3	Most reflexes (especially tendon reflexes) absent, but only minimal respiratory or circulatory depression.
Class 4	Respiratory depression with cyanosis or circulatory failure with shock. No reflexes present.

After the patient is stable, the depth of depression is estimated. A scale proposed by Reed, Driggs and Foote is extremely helpful[17] (Table 4). Patients in classes 0 to 2 usually recover with symptomatic care such as hydration, alkalization, and the use of an osmotic diuretic.[18] Those in classes 3 and 4 require more vigorous therapy, such as hemodialysis; especially in patients with deepening coma with hypotension and further complicating pulmonary edema or impaired renal function.

We have, to date, dialyzed six patients with circulatory poisons of the class 4 type and have an overall survival rate of 100 per cent. This is a dramatic example of how supportive and therapeutic medicine can merge together on a specific problem. With the greater application of these principles, many useful, young, and intelligent lives can be spared from death by acute poisoning.

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1945 Corlies Avenue

In diabetes, management of keto-acidosis requires swift decision-making, and a practical guide to that is here offered.

Treatment Of Diabetic Ketoacidosis With Insulin

How much? When?

Bernard Robins, M.D./Westfield

Management of the patient with diabetic ketoacidosis is an experience in multiple simultaneous decision making. Standardization of the treatment program provides a baseline which frees the clinician to concentrate on the unique problems which each patient will present.

Such standardization will include the following factors: treatment protocol and flow sheet; timing of laboratory studies; ancillary diagnostic studies; and choice of intravenous fluids, alkalinization, potassium replacement, and perhaps most controversially, the amount and timing of insulin administration.

The complex factors which influence the choice of initial and subsequent insulin dosages include: the size and the age of the patient;[1,2] the length of time the patient had the disease; the degree of hyperglycemia,[3] acidosis, and ketonemia;[4] the presence of complicating factors; and the presence of insulin resistance.[5]

Our work in this area has led us to rely more heavily on the degree of ketonemia and the size of the patient, rather than any other factor in choosing the initial dosage of insulin, especially in the newly diagnosed case. We were able to establish a formula based upon the above factors which has good correlation with successful management.

In seven cases, the initial dosage of regular insulin was given so that the following formula was applicable:

Insulin Units per KGM = 1 + Number of times serum diluted with saline and still 4+ acetone

Table I

SERUM DILUTIONS		PER CENT OF ORIGINAL SERUM IN FINAL DILUTION	NUMBER OF TIMES SERUM HAD BEEN DILUTED WITH EQUAL SALINE	UNITS OF INSULIN PER KILO OF BODY WT.
PARTS OF SERUM	PARTS OF SALINE			
1	0	100%	0	1
1	1	50%	1	2
1	3	25%	2	3
1	7	12½%	3	4
1	15	6¼%	4	5

UNITS INSULIN/KGM = (NUMBER OF TIMES SERUM DILUTED) + 1

Table I shows the relationship. The serum acetone test is performed by taking 4 cubic centimeters of serum or plasma and testing it for acetone with acetone test powder or tablet. A four-plus reaction is an indication to dilute the serum or plasma with an equal volume of saline. This is a 50 per cent concentration and is tested again for acetone. If a four-plus reaction is achieved, this 50 per cent solution is diluted with an equal volume of saline to give a 25 per cent solution. If this is four plus for acetone then the solution is equally diluted again to give a 12.5 per cent solution. Again the dilution will go to 6.25 per cent if the reaction is four-plus positive for acetone.

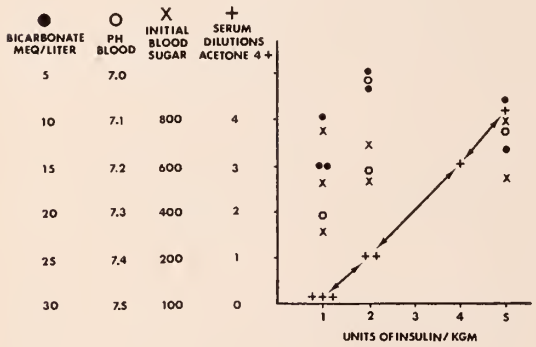
Insulin in the seven cases treated was generally given in one dose at the onset of treatment or as soon as the serum acetone was known. The therapy also included standard hypotonic saline solutions, alkalinization with bicarbonate when indicated[6], potassium replacement if needed,[7] and antibiotics if indicated.

Follow-up insulin dosage in these cases was generally determined by the clinical and laboratory status of the individual patient. The pertinent data concerning the initial insulin administration are contained in Table II.

Table II

CASE	AGE	WT. IN KGM.	INITIAL BLOOD SUGAR	PH	SERUM ACETONE 4+	HCO_3^-	INITIAL DOSE	SUGAR AT 4-6 HRS.	NO. OF DILUTIONS	UNITS PER KGM.
1	1.5	10	560	7.14	1:15	9	55	128	4	5
2	1.5	9.5	750	-	UNDIL.	15	10	86	0	1
3	8	26	560	7.04	1:1	6.9	50	289	1	2
4	10	25	654	7.21	1:1	8.5	50	115	1	2
5	37	65	345	-	UNDIL.	11	60	117	0	1
6	30	61	690	-	1:7	14	240	282	3	4
7	83	58	525	7.3	UNDIL.	15	58	370	0	1

Graph 1



Excellent correlation between the initial insulin dosage in units per kilogram and the serum acetone concentration is shown in Graph I. But the lack of correlation between the insulin dosage and the initial blood glucose, pH or bicarbonate are also shown.

Our policy for insulin administration may be summed up as follows:

(1) The patient is weighed on admission (or the weight is closely estimated) and serum acetone is tested.

(2) Total initial insulin dose is calculated from the formula described previously. The total amount is given at once.

(3) No further insulin is given until the fourth hour of treatment although the urine may be monitored hourly.

(4) At the fourth hour the second dose of insulin is given based on the clinical status, urinary findings and (most important) the repeat blood sugar at the fourth hour. The dosage schedule of Shaw *et al.*[8] may be judiciously employed at this point. The fourth hour dose is:

$$\text{4th Hour Dose} = \frac{\text{(4th Hour Glucose-200)}}{\text{(Initial Glucose-4th Hour Glucose)}} \times \text{Initial Dose}$$

(5) If the fourth hour glucose is less than 200, intravenous glucose is started and insulin is withheld.

(6) Unresponsiveness of the blood glucose at the fourth hour test suggests marked insulin resistence. This indicates the need for an aggressive insulin program.

(7) All of the insulin is given subcutaneously unless there is a significant degree of shock. The use of insulin by the intravenous route may change its duration of action and its degree of effectiveness to the extent that the use of formulae may be invalidated.

(8) The level of consciousness, the degree of dehydration, the level of hyperglycemia, or the extent of acidosis, are not considered in deciding the initial insulin dosage, but only the degree of ketonemia and the body weight.

However, all other therapeutic measures are carried out according to the usual accepted criteria.

Summary

1. A method of standardization of insulin therapy in diabetic ketoacidosis is described.

2. Its use in seven cases is illustrated.

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1009 Tice Place

In 1907, physicians had to band together to set up their own study groups in basic sciences. Now it is all done for us.

The Essex County Pathological And Anatomical Society

A Belated Obituary

Samuel Berg, M.D./Newark

For half a century, the Essex County Pathological and Anatomical Society was one of the most active medical educational organizations in New Jersey. Until recently, it was the only one in the state which had the legal authority to obtain bodies for dissection for teaching. Only lately has our legislature permitted dissection in medical colleges. Dr. Martland held Clinico-Pathological Conferences at Newark City Hospital Tuesday nights which were so well attended that a large amphitheatre was especially constructed and equipped with the financial assistance of the Society. In 1935, the Society sponsored the Harrison S. Martland Annual Lecture. Among the celebrated speakers, some of whom were Nobel Prize winners, were Whipple, Ewing, Libman, Waksman, Boyd, Goldblatt, Loewi, duVineaud, Lawrence, Warren, Klemperer, and Farber. The Society was renowned nationally. It was my privilege to relate its history on the occasion of the 50th Anniversary celebration in November 1957.*

Even then changes were taking place in medical education and in private and hospital practice which presaged the decreasing influence of the Society, centered in Newark around one eminent physician with the main source of clinical and pathological material in Newark City Hospital. Then, there was the increasing influence of medical centers arising or enlarging in adjacent cities and towns. This development, foreboding for the Society, was pointed out in the anniversary address. By a strange quirk of fate, it became my unhappy concern to preside over the dissolution of the Society.

What turned out to be the last Annual Dinner and Martland Memorial Lecture (Dr. Martland died in 1954) was held in December 1961. The guest speaker was Dr. Averill A. Liebow, Professor of Pathology at Yale. Sentiment entered into inviting this speaker, for Professor Liebow had paid his respects to Dr. Martland, as the pioneer researcher on the effects of ingested radioactive materials, by visiting and consulting him at his laboratory before writing his definitive articles on the pathology of nuclear bomb injuries.

For several years thereafter, though no meetings or conferences were held, very few members made inquiries relating to the activities of the Society. When it became certain that the Society could not be revived to offer educational services unavailable elsewhere in northern New Jersey, the decision was made to have the Society, in a dying gesture, toss

* Published in *The Journal* of The Medical Society of New Jersey, 56:2 (February 1959). Reprints available on request to Dr. Berg.

the torch to others to carry on the good works to which it had been dedicated for half a century, as evidenced by the following letter.

August 30, 1967

The President
Academy of Medicine of New Jersey
Bloomfield, New Jersey

The Director
New Jersey Historical Society
Newark, New Jersey

Sirs:

The Essex County Pathological and Anatomical Society, after more than fifty years of service to the physicians of northern New Jersey, has seen fit to end its existence because its prime mission of education has been assumed in recent years by every accredited hospital in Essex County. It was decided to divide the balance of the treasury into two equal parts, offering one as a grant to the Academy of Medicine of New Jersey and the other to the New Jersey Historical Society.

These grants are made with the hope and expectation that the two organizations will use the funds to make acquisitions relating either to medical education or to history, particularly as they pertain to New Jersey, thereby serving to perpetuate the memory of the Essex County Pathological and Anatomical Society which was very active in both fields.

Accordingly, a check in the amount of $2,624.61 is hereby submitted in anticipation of its acceptance on the above basis by the trustees of these organizations.

Very truly yours,

Samuel Berg, M.D.
President

Richard A. Hopping, M.D.
Secretary-Treasurer

The Academy of Medicine of New Jersey has set aside part of the grant to purchase books for its library pertaining to the history of medicine in New Jersey, and part to establish an award to be presented to the second-year student in each medical school of the State who shows outstanding promise in pathology.

The New Jersey Historical Society will use the grant to make acquisitions relating to medical education or history, particularly as they pertain to New Jersey.

The Essex County Pathological and Anatomical Society is dead.

Long live the Essex County Pathological and Anatomical Society!

156 Roseville Avenue

Home Care For Arthritics

A new booklet which tells arthritis patients how they can prevent deformity is now available. Entitled *"Home Care Programs in Arthritis,"* this 24-page illustrated booklet was prepared by members of the Arthritis Foundation. Physicians may want to give this booklet to their patients as a supplement to the treatment they prescribe.

"Because arthritis is a chronic lifetime disease, what the patient knows and does about it on a daily basis at home is the key to successful treatment" says William E. Reynolds, M.D., medical director of The Arthritis Foundation.

"But no professional helper can live with the patient around the clock the way he must live with his arthritis. In the final analysis, whether the patient recovers without deformity or ends up a cripple with burnt-out joints depends on how well the patient has helped himself, under medical direction. That's why this manual on home care may be the most important single publication ever issued by The Arthritis Foundation," he says.

The booklet combines common sense advice to the arthritis patient with discussion of posture, rest, illustrated exercises, use of heat, cold, splints, canes, crutches, self-help devices, and ways in which home surroundings can be modified for the disabled arthritis sufferer.

Copies of *Home Care Programs in Arthritis—A Manual for Patients* may be obtained by physicians from The Arthritis Foundation, 1212 Avenue of the Americas, New York, New York 10036.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

May 21, 1969

The reorganization meeting of the Board of Trustees, for the administrative year 1969-1970, was held in Atlantic City on May 21, 1969. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

New Members . . . Welcomed the following new members to the Board: Dr. William J. D'Elia (2nd Vice-President); Dr. Charles L. Cunniff (Secretary); Dr. Edward G. Bourns (Trustee from the 1st District); Dr. Robert C. Anderson (Trustee from the 1st District); and Dr. I. Edward Ornaf (Trustee from the 4th District). Dr. James A. Rogers (Trustee from the 2nd District) was unable to attend.

Chairman — 1969-1970 . . . Elected Dr. Thomas C. DeCecio of Cliffside Park as Chairman of the Board of Trustees for 1969-1970.

Secretary — 1969-1970 . . . Re-elected Dr. Louis F. Albright of Spring Lake as Secretary of the Board of Trustees for 1969-1970.

Meeting Schedule . . . Agreed to continue meeting regularly at 10:45 a.m. on the third Sunday of each month, subject to cancellation should the agenda prove insufficient.

Finance and Budget . . . Re-elected Dr. David Eckstein of Trenton as a Trustee-member of the Committee on Finance and Budget for a three year term (1969-1972).

AMA Annual Meeting . . . Confirmed authorization of the following to attend the July Annual Meeting of the American Medical Association in New York City, with expenses paid: President, President-Elect, Executive Director, seven Delegates, and two Alternate-Delegates (Dr. John J. Bedrick of Bayonne and Dr. Robert E. Verdon of Cliffside Park).

. . . Authorized Dr. Matthew E. Boylan of Jersey City to attend in the absence of Dr. Marcus H. Greifinger.

AMA Clinical Convention . . . Confirmed authorization of the following to attend the Clinical Convention of the AMA in Denver, Colorado (November 30 to December 3), with expenses paid: President, President-Elect, Executive Director, seven Delegates, and one Alternate-Delegate (Dr. Louis F. Albright of Spring Lake).

. . . Authorized Dr. Jerome G. Kaufman of Maplewood to attend the meeting in the absence of Dr. Marcus H. Greifinger.

Reappointment of Salaried Personnel . . . Reappointed for 1969-1970, at the salaries set forth in the adopted budget, all salaried personnel not under individual contract.

Staff Commendation . . . Commended the staff for the success of the 1969 Annual Meeting.

Legal Counsel . . . Appointed Mr. E. Powers Mincher as Legal Counsel to the Society.

Referrals From 1969 House of Delegates . . .

(1) *Assimilation of Osteopaths* . . . Empowered the Chairman, in conjunction with the Executive Committee, to set up a special committee to implement the Reference Committee recommendation (adopted by the House) concerning Resolution #1 (Essex County) and Resolution #2 (Hudson County). (See page 410, July 1969 JOURNAL)

(2) *Relative Value Index* . . . Directed that Resolution #4 (Board of Trustees) be referred to the Council on Medical Services for implementation. (See page 410, July 1969 JOURNAL)

(3) *Use of Medical Credit Cards* . . . Directed that Resolution #28 (Burlington County), as

amended by the Reference Committee and adopted by the House, be called to the attention of the membership, as indicated, and that the item be referred to *The Journal* and to the component societies. (See page 411, July 1969 JOURNAL)

(4) *MSP-HSP Coverage for Psychiatric Patients* . . . Referred Resolution #19 (Morris County) to the Permanent Committee on Blue Cross and Blue Shield Plans of New Jersey. (See page 414, July 1969 JOURNAL)

(5) *Medical Students to Attend MSNJ 1970 Annual Meeting* . . . Referred a recommendation of Reference Committee "D" — to extend an invitation to the medical students of the two New Jersey medical colleges to attend the 1970 Annual Meeting of MSNJ — to the Committee on Medical Education and the Committee on Annual Meeting. (See page 415, July 1969 JOURNAL)

(6) *Amend Abortion Laws* . . . Referred Resolution #6 (Essex County) to the Council on Legislation. (See page 416, July 1969 JOURNAL)

(7) *Utilization of Physicians' Services Under Part B of Medicare* . . . Directed that a recommendation of Reference Committee "E" — concerning utilization guidelines for the fiscal intermediary (Prudential) — be referred to the President. (See page 418, July 1969 JOURNAL)

(8) *Chiropractic* . . . Referred Resolution #7 (Bergen County) to the Council on Legislation for implementation. (See page 419, July 1969 JOURNAL)

(9) *Welfare Recipients* . . . Directed that a recommendation from Reference Committee "E" — concerning problems relating to signing of prescriptions and other necessary documents by interns and residents in hospitals with approved training programs — be referred to the President. (This recommendation resulted from discussion on Resolutions #15 (Middlesex County) and #23 (Delegate from Union County) which were *not adopted* by the House. (See pages 420, July 1969 JOURNAL)

(10) *Mental Health Program Study Group* . . . Directed the President to call to the Governor's attention Resolution #21 (Delegates from Bergen, Monmouth and Passaic Counties) concerning a new structure for mental health care in New Jersey. (See page 423, July 1969 JOURNAL)

(11) *Conservation of Vision* . . . Referred a recommendation from Reference Committee "G", as amended and adopted by the House — to insure that only licensed medical practitioners and their legally authorized assistants be permitted (under the direction of physicians) to use drugs in eye examinations — to the Conference Committee on the Control of Eye Medication. (See page 424, July 1969 JOURNAL)

(12) *School Bus Safety* . . . Referred Resolution #17 (Bergen County) to the Committee on Traffic Safety. (See page 425, July 1969 JOURNAL)

(13) *Standardized College Health Report Form* . . . Directed that Resolution #20 (Camden County) be referred to the Chairman of the New Jersey Delegation to the AMA. (See page 425, July 1969 JOURNAL)

(14) *FAA Medical Examination Form For Pilot Certification* . . . Referred a recommendation from Reference Committee "H" — concerning legislation to render physicians immune from suits for reporting disqualifying conditions to the FAA — to the Council on Legislation. (See page 426, July 1969 JOURNAL)

(15) *Annual Meeting* . . . Authorized the President, President-Elect, Chairman and Vice-Chairman of the Committee on Medical Education, and Chairman of the Board of Trustees to meet with the Annual Meeting Committee to discuss a recommendation from Reference Committee "H"—concerning future Annual Meeting programs — and report to the Board of Trustees at its next meeting. (See page 426, July 1969 JOURNAL)

American Board of Immunology and Allergy . . . Referred a resolution calling for MSNJ

endorsement of a request to the AMA House of Delegates for the creation of a Board of Immunology and Allergy to the Chairman of the New Jersey Delegation to the AMA.

Daytop Village . . . Authorized a $250 contribution to Daytop Village in recognition and support of its endeavors.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Disease during the months of May and June.

	May 1969	*May 1968*
Aseptic meningitis	10	6
Primary encephalitis	1	4
Post-infectious encephalitis	0	1
Hepatitis: Total	178	164
Infectious	144	148
Serum	34	16
Malaria	13	5
Military	11	5
Civilian	2	0
Meningococcal meningitis	17	19
Mumps	314	460
German measles	131	361
Measles	226	149
Salmonella	61	65
Shigella	21	23

	June 1969	*June 1968*
Aseptic Meningitis	9	10
Primary Encephalitis	2	5
Post-Infectious Encephalitis	0	0
Hepatitis, Total	193	178
Infectious	45	161
Serum	148	17
Malaria (Servicemen)	11	9
Meningococcal Meningitis, Total	12	12
Civilian	9	
Military	3	
Mumps	212	223
German Measles	42	215
Measles	195	108
Rocky Mt. Spotted Fever	2	1
Salmonella	50	39
Shigella	39	5

Parasitic Disease Drug Service

The Parasitic Disease Drug Service of the National Communicable Disease Center has now been in operation for almost two years. This service was organized to satisfy the growing demand for antiparasitic agents, many of which are unlicensed or not readily available in this country. With increasing involvement of Americans in tropical areas and more sophisticated medical diagnosis it is likely that the number of requests for antiparasitic drugs will continue to increase in the future.

Eight of the drugs available on an investigational basis are: Astiban, Dehydroemetine, Suramin, Bayer 2502, Bithionol N.F., Pentamidine isethionate, Niclosamide, Parenteral Chloroquine and Parenteral Quinine.

A brief description of these drugs follows:

1. Astiban (Sodium antimony dimercaptosuccinate, TWSb) is used in the treatment of schistosomiasis caused by *Schistosoma hematobium* and *Schistosoma mansoni*. In the United States, schistosomiasis is most commonly seen in people who have lived in rural areas of Puerto Rico. In most cases Astiban can be given on an ambulatory basis over a short period of time.

2. Dehydroemetine (for I.M. or subcutaneous use) is for the treatment of severe intestinal amebiasis and extraintestinal amebiasis i.e., liver abscess. Amebiasis is cosmopolitan in its distribution. Both introduced and indigenous cases are seen in the United States. The advantage of dehydroemetine over emetine is that it is less toxic yet equally as effective.

3. Suramin is available for the treatment of the early stages of sleeping sickness due to *Trypanosoma rhodesiense* and for the treatment of onchocerciasis (usually in combination with diethylcarbamazine). African trypanosomiasis is a potentially serious disease seen in expatriates and U.S. citizens who have traveled through endemic areas in Africa. Onchocerciasis, a disease of the skin and eyes, is seen in expatriates and U.S. citizens who have lived in endemic areas in West Africa, Mexico, Central America and northern South America.

4. Bayer 2502, a nitrofurfurylidine derivative, is for the treatment of sporadic cases of Chagas' disease in the United States. Only two indigenous cases have been described in the United States but Chagas' disease is occasionally seen in South and Central American expatriates and accidentally infected laboratory workers.

5. Bithionol, N.F. is used in the treatment of paragonimiasis. In the United States, paragonimiasis is usually seen in individuals who have traveled through China, Korea, Japan, Southeast Asia, West Africa or northwestern South America. It is acquired through the ingestion of poorly cooked or freshly-salted crustacean meat or juices and is usually manifested by chronic lung disease, although subcutaneous, cerebral and abdominal complications can occur.

6. Pentamidine isethionate (Lomidine) is used in the treatment of *Pneumocystis carinii* pneumonia and the early stages of sleeping sickness due to *Trypanosoma gambiense*. *Pneumocystis carinii* pneumonia is a serious infection seen in neonates, debilitated infants and adults with altered immunologic responses (usually in association with a malignancy).

7. Niclosamide (*Yomesan*) is indicated in cestode infec-

tions due to *Taenia saginata, Hymenolepis nana* and *Diphylidium caninum* (in man). The prime advantages of this drug are that it can be given to ambulatory patients and it is relatively non-toxic.

8. Parenteral Chloroquine and *Parenteral Quinine* are antimalarials, licensed in and commercially available in the United States. They have sometimes been difficult to obtain rapidly. Although it is preferable that they be procured through commercial channels, a supply of both is stocked by the Parasitic Disease Drug Service for emergency use.

Requests for these drugs should be made through the Communicable Disease Control Program of the New Jersey State Health Department. (609-292-5590). At hours when the Health Department offices are closed, call 609-392-2020.

Measles Surveillance and Immunization Activities

During the first four months of 1969, 411 clinically confirmed cases of measles were reported to the State Health Department. This number represents a 34 per cent increase over the cases reported during the same period last year. Undoubtedly some of this increase is due to improved surveillance activities. Detailed clinical information is obtained on each case of reported measles and, of the reported cases, approximately 10 per cent are felt to be other rash illnesses. Each case is questioned for contacts, who in turn are followed. If there is a clustering of cases in a school, a susceptibility survey is undertaken to see if a vaccination program is warranted. More than 75 per cent of the cases occurred in six cities — Newark, Passaic, Paterson, Jersey City, Union City, and Pennsauken. Measles immunization programs have been carried out in these cities.

According to the Morbidity and Mortality Weekly Report (May 3, 1969), 9,615 cases of measles had been reported for the United States during the first 16 weeks of 1969. This was 92 per cent and 26 per cent of the cases reported for the comparable periods in 1968 and 1967. Along with New Jersey, 17 other states reported an increase in measles cases for the first quarter of 1969 compared with the same period last year.

Meningococcal Meningitis

Meningococcal meningitis and meningococcemia persist as a public health problem. In order to document the occurrence of sulfonamide-resistant meningococci, all clinical isolations should be sent to the State Bacteriology Laboratory, where the cultures are sent for resistance studies and serogrouping. During 1969, sulfadiazine resistant strains of meningococci have been reported from Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Union, and Somerset Counties. The majority of these strains have been serogroup C but there have been a few serogroup B strains.

Of the 72 isolates tested thus far in 1969, 91 per cent have been sulfonamide-resistant. Fifty-seven of the isolates were from military personnel of which 96 per cent were sulfonamide-resistant. In the civilian population ten out of fifteen cultures were sulfonamide-resistant. Because of the widespread occurrence of sulfonamide-resistant meningococci, penicillin is the drug of choice for treatment.

Though primarily due to increased cases in the military population, there has been a rise in meningococcal disease in New Jersey since 1965.

Year	*Civilian Cases*	*Military Cases*	*Total*	*Per cent Change from previous year*
1965	69	16	85	
1966	82	53	135	+59
1967	66	58	124	−8
1968	76	197	273	+121
1969 (Jan.-April)	51	47	98	+8

During the first four months of 1969, 16 of the 21 counties had reported cases of meningococcal meningitis.

Medical Journals May Be Taxed

The American Medical Association has told Congress that the Internal Revenue Service acted arbitrarily in imposing a tax on revenue from drug advertising in journals of tax-exempt medical associations. According to a recent AMA release, Bernard D. Hirsh, AMA

general counsel, testified that the relation between the tax-exempt purposes of a medical association, national or state, and the drug advertising in its journal is self-evident.

"Drug advertising alerts and stimulates the physician's interest in new drugs as they become available, and also serves to remind him of the broad spectrum of useful, time-proved drugs. Physicians do not rely upon drug advertisements as their principal source of information, but drug advertisements often provide an important step in the process through which physicians become educated in the therapeutic value and risks of new drugs and a wider variety of useful drugs. Indeed, no other advertising provides as much complete and objective information."

Hirsh said the IRS regulations taxing medical associations on their advertising revenues represents an attempt to change the law without congressional action. The IRS officials made a mistake, he said, and he urged that this mistake be rectified expeditiously and in the most practical way possible."

Spokesmen for other tax-exempt associations joined the AMA in opposing the tax on their advertising revenues. These included the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Dental Association, the Boy Scouts of America, the Girl Scouts of America, the American Chemical Society and the Society of National Association Publications.

Representatives of commercial publishing firms, however, contended that the previous tax exemption gave the journals of the associations an unfair advantage in competition for advertising dollars. When the IRS announced the new tax regulations 15 months ago, it stated that the purpose of the regulations was not to raise federal revenue but to remove a competitive advantage of the tax-exempt associations. The Internal Revenue Service said that it also is considering taxing the income that these exempt associations get from rental of exhibit and display space at conventions.

Exploitation Of Medicare And Medicaid

The American Medical Association has offered to cooperate in a Senate investigation of large medicare and medicaid payments to physicians and other health practitioners.

The offer followed a Senate speech by Sen. John J. Williams (R., Del.) in which he reported that the staff of the Senate Finance Committee had found that several thousand doctors, dentists and others in 1969 had received $25,000 or more each for their services under the two government programs. Senator Williams reacted to the AMA offer, saying:

"This is the type of cooperation we need. I appreciate this support from the American Medical Association and I sincerely hope that we shall have similar pledges of support from representatives of the other groups affected.

"I can assure each of these groups that our study will not result in a blanket indictment against any segment of the industry involved. We fully recognize that the overwhelming proportion of those connected or working with this program are trying to do a good job; however, when exploitation or excessive charges are discovered they must be exposed and properly dealt with."

Williams said that the committee's investigation already had shown:

"First, in 1968 the medicare program paid $25,000 or more to each of at least 5,000 physicians.

"Second, thousands of health practitioners — doctors, dentists, optometrists, and others — were each paid $25,000 or more under the welfare health care programs in 1968. . . . A surprising note is the large number of dentists appearing on the lists from welfare agencies.

"Tabulations have been prepared comparing the average Medicare payments for the most common surgical procedures for older people with the maximum payments allowed under the most widely held Blue Shield contract in the same geographical area. Results are startling. Medicare's average payments run as much as two to four times as high as Blue Shield maximums. For example, in two areas of the country Medicare's average payment for a cataract operation is more than four times as much as the Blue Shield allowance. These are not isolated cases. There is a pronounced pattern of inflated payments by Medicare.

"The report to the committee will include pinpointing the causes underlying these extremely generous handouts of public funds.

"Another unusual situation has occurred in Social Security pressing carriers to pay for so-called supervisory services rendered by a teaching physician even though the actual care is provided by an intern or resident. Before Medicare virtually no insurer paid for such services. . . .

"The investigation has expanded the evaluation of carrier and intermediary performance to determine whether the Government is getting what it is paying for and the extent to which intermediaries and carriers are carrying out specific functions assigned to them by the Medicare statute.

"A wide variance and level of performance has been observed. The law requires intermediaries and carriers to exercise effective controls on utilization of services. But some carriers and intermediaries appear to ignore performance of this vital function while others seem to be doing a reasonably effective job."

The AMA has issued a statement saying that it shared with the Senator a concern over the rising costs of Medicare and Medicaid: "For some time, the AMA has been giving national leadership in coordinating the efforts of state and county medical societies in the establishment and effective functioning of local review and utilization committees checking on the health care services rendered under the Medicare and Medicaid programs. Close liaison also has been established between carriers and many medical societies in reviewing disbursements under the government programs.

"All investigations so far have indicated that an overwhelming majority of physicians participating in Medicare and Medicaid are charging reasonable fees. The charges of only about two per cent of the physicians receiving payments from the programs have been challenged. The AMA favors appropriate action in any of the cases where physicians are found to receive improper payments. The AMA Board of Trustees has urged all state and local medical societies 'to act swiftly and firmly in all instances of known exploitation, and excessive charges for health care that may occur in their jurisdiction.' Indeed several medical societies have expelled members where it has been proved that a physician's charges were excessive or he in some other way exploited the program.

"The AMA has been emphasizing to physicians the responsibility they have to hold down the health care costs of their patients both under and outside government programs. In an April 17 letter to Finch, Dr. Wilbur said the AMA 'is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people.'

"The knowledge and judgment of the nation's physicians — as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others — must be enlisted in your battle against the health-care portion of the inflation problem."

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Claude Magnant, M.D., 710 Zumbro Drive, NW, Rochester, Minnesota 55901. Temple, 1963. Board Eligible. Group or partnership. Available July 1969.

CARDIOLOGY—Richard Helfant, M.D., Peter Bent Brigham Hospital, Boston, Massachusetts 02115. NYU — Bellevue 1963. Board eligible. Cardiac catherization laboratory in hospital. Available July, 1970.

DERMATOLOGY—Charles Wasilewski, Jr., M.D., 205 Oak Street, Danville, Pennsylvania 17821. Jefferson, 1963. Board eligible. Multispecialty group. Available July 1969.

INTERNAL MEDICINE—David A. Berkowitz, M.D., 2408A Snark Street, Griffiss AFB, New York 13440. New York Medical, 1963, Board eligible. Group or partnership. Available July 1969.

David Lemper, M.D., 8700 West Wisconsin Avenue, Milwaukee, Wisconsin 53226. University of Pennsylvania, 1965. Subspecialty, nuclear medicine. Solo, group or partnership. Available July 1969.

Edward Lebowitz, M.D., 37 Saranac Avenue, Lake Placid, New York 12946. Downstate Medical Center (NYU), 1963. Board eligible. Subspecialty, diabetes and endocrinology. Group or partnership. Available.

OBSTETRICS AND GYNECOLOGY — Donald S. Cohen, M.D., 2512A Atlas Drive, Griffiss Air Force Base, New York, 13440. Columbia, 1962. Board certified. Partnership or group. Available July 1969.

Harold M. Yatvin, M.D., Kirk Army Hospital, Aberdeen Proving Ground, Aberdeen, Maryland 21001. New York Medical, 1962. Board eligible. Group. Available August 1969.

Jerry A. Wider, M.D., 315 Congressional Lane, Rockeville, Maryland 20852. Columbia, 1963. Board eligible. Partnership or Group. Available July 1969. Ronald P. Portadin, M.D., 296-B Bizerte Road, Fort Lee, Virginia 23801. Georgetown, 1962. Board eligible. Associate. Available July 1969.

Louis V. Miller, M.D., 353 Rolling Hill Road, Elkins Park, Pennsylvania 19117. Ohio State, 1959. Board eligible. Group or partnership. Available July 1969

OPHTHALMOLOGY — Franklin L. Bocian, M.D., 54 Orange Street, Brooklyn, New York 11201. Downstate Medical Center (NYU), 1964. Solo or associate. Available July 1969.

ORTHOPEDICS—Seymour Einhorn, M.D., 2nd General Hospital, Box 24, APO 09180, New York. New York Medical, 1957. Board Certified. Partnership. Available September 1969.

PATHOLOGY—Martin Berman, 6309 Winner Avenue, Baltimore, Maryland 21215. Downstate Medical Center (NYU), 1961. Board certified. Group, partnership, institution. Available July 1969.

PEDIATRICS—Franz Hummert, M.D., 58 Pine Grove Terrace, Newark 07106. Muenster, West Germany 1961. Board eligible. Group or partnership. Available November 1969.

SURGERY—Malcolm H. Sawyer, M.D., HQ, 3rd Air Force, Box 1563, APO New York 09125. Northwestern, 1936. Board eligible. Industrial or administrative. Available September, 1969.

Warren X. Collmann, M.D., 77 Penn Drive, West Chester, Pennsylvania 19380. University of Pennsylvania, 1950. Board certified. Group, partnership, or solo. Available.

Pun Fai Yuen, M.D., 413 USPH Hospital, Lawton, Oklahoma 73501. St. Louis University School of Medicine, 1960. Board eligible. Group. Available October 1969.

THORACIC—CARDIOVASCULAR SURGERY—John K. Garan, M.D., Medical College of Georgia, Augusta, Georgia 30902. University of Paris (France) Medical School, 1961. Partnership, Group, Associate. Available July 1969.

UROLOGY—Albert P. Tarasuk, M.D., 350 East 17th Street, New York, New York 10003. George Washington, 1964. Associate. Available July 1969.

Alfred R. Bozzo, M.D., 3106 Holly Street, Alexandria, Virginia 22305. Georgetown, 1962. Board eligible. Solo or partnership. Available July 1969.

Myron M. Smith, M.D., 1115 Sixth Street, SW, Minneapolis, Minnesota 55414. NYU (Downstate) 1962. Board Eligible. Partnership. Available July 1969.

Chairmen Councils and Committees 1969-1970

Alcoholism
Henry J. Mineur, M.D., Cranford

Annual Meeting
James A. Rogers, M.D., Paterson

Cancer Control
John L. Olpp, M.D., Englewood

Child Health
William J. Farley, M.D., Nutley

Conservation of Vision, Hearing, and Speech
Frank B. Vanderbeek, M.D., Paterson

Credentials
Charles L. Cunniff, M.D., Jersey City

Drug Abuse
Henry A. Davidson, M.D., East Orange

Emergency Medical Care
Jack R. Karel, M.D., Hillside

Emotional Disorders of Childhood and Adolescence
Eugene V. Resnick, M.D., Paramus

Environmental Health
Roslyn Barbash, M.D., Teaneck

Finance and Budget
Thomas C. DeCecio, M.D., Cliffside Park

Honorary Membership
Ralph M. L. Buchanan, M.D., Phillipsburg

Judicial
John S. Madara, M.D., Salem

Legislation
Jesse McCall, M.D., Newton

Maternal and Infant Welfare
John D. Preece, M.D., Trenton

Medical Defense and Insurance
William J. D'Elia, M.D., Neptune City

Medical Education
Morris H. Saffron, M.D., Passaic

Medical Services
Louis K. Collins, M.D., Glassboro

Medical Student Loan Fund
Frank J. Hughes, M.D., Gloucester

Medicine and Religion
Luke A. Mulligan, M.W., Leonia

Mental Health
Robert S. Garber, M.D., Belle Mead

Mental Retardation
Miles E. Drake, M.D., Vineland

Occupational Health, Workmen's Comp. & Rehab.
Joseph A. Lepree, M.D., Elizabeth

Project Hope/Vietnam
Thomas C. DeCecio, M.D., Cliffside Park

Publication
George B. Sharbaugh, M.D., Trenton

Public Health
Rudolph G. Matflerd, M.D., New Brunswick

Public Relations
John J. Crosby, M.D., Jersey City

Retirement Plan for Physicians
Nicholas E. Marchione, M.D., Vineland

Revision of Constitution and Bylaws
Fred A. Mettler, M.D., Blairstown

Seizures
J. Lloyd Morrow, M.D., Passaic

Traffic Safety
Irwin S. Smith, M.D., Willingboro

Woman's Auxiliary Advisory
Keith R. Young, M.D., Burlington

The Clubby Road For The Chubby

The American Medical Association has issued a warning concerning commercially promoted "clubs" for weight losers. "After all," they said, "since excess weight may be a symptom of disease, any person who wants to lose weight should have a meticulous examination by his physican before participating in any of these club programs." Many such clubs are operated locally by businessmen who obtain franchises from a national headquarters organization.

"The regimen and rapport of group workouts, commercially promoted, may give the overweight person some moral support for his effort at weight reduction and little else," the AMA said. "The group approach may be satisfactory for the person who wants to lose a few pounds and can afford the fee charged by a club.

"The group approach that does not include an honest and thorough physical examination and medical supervision is definitely *not* satisfactory for the significantly overweight, person; nor for one who plans to lose 15 per per cent or more of his total weight. Significant weight reduction must be carried out under the supervision of a physician." The AMA then added that, "there is in the overweight population a higher incidence of hypertension, cardiovascular and kidney diseases, disorders of the liver and gallbladder, and diabetes mellitus.

"Sudden loss of significant amounts of weight, or the requirement for an unusual amount of exercise, may be hazardous for the patient with any of these conditions. "Adequate treatment of obesity is often a more complex matter than diet and exercise, which constitutes the traditional club regimen. While simple over-eating and under-exercising may be a cause of obesity, significant overweight frequently has a genetic, metabolic, or emotional component which requires medical diagnosis and treatment." Because there is no single cause of obesity, there is no single proper treatment to correct it."

Antibiotic Combinations

The Food and Drug Administration has taken the first step to halt the marketing of 78 antibiotic combination products. This action was recommended by the National Academy of Sciences-National Research Council, which is evaluating the effectiveness of 3,600 new drugs marketed from 1938 to 1962.

Generally, the 78 products were found ineffective as fixed combinations for claims made in their labeling. The FDA emphasized that this does not necessarily mean that either the antibiotics or other active ingredients of the products are ineffective when used alone. "But the use of two or more active ingredients in the treatment of a patient who can be cured by one is irrational therapy," said Herbert L. Ley, Jr., M.D., Commissioner of Food and Drugs. "It exposes the patient to an unnecessary risk. Antibiotics should be used like a rifle rather than a shotgun."

Most of the 78 products are antibiotic-sulfa combinations in tablet, capsule, or liquid form. Also included are 16 penicillin-streptomycin combinations that are given by injection. Other antibiotics used in the preparations include erythromycin, neomycin, tetracycline, chlortetracycline, nystatin oxytetracycline, oleoandomycin, and triacetyloleandomycin. In addition, some of the preparations contain analgesics, vitamins, or other ingredients.

Many of the affected products have been promoted widely and found wide acceptance in the medical profession. Several of the manufacturers promptly said they would contest the FDA ruling. The manufacturers were given 30 days to submit any new data on efficacy of the products.

The FDA can halt the marketing of antibiotic-containing preparations by deleting them from regulations listing the antibiotic drugs acceptable for certification. Antibiotics and insulin, unlike other drugs, must be certified on a batch-by-batch basis before they can be marketed.

OBITUARIES

Dr. Samuel S. Butler

For decades one of Camden County's most prominent members, Samuel S. Butler, M.D. died on April 26, 1969 at the age of 84. He earned his M.D. at the old "Medico-Chi" in Philadelphia in 1916. Dr. Butler was a family doctor with a special interest in otolaryngology. He retired some years ago and was living in Ocean City at the time of his death.

Dr. Francis H. DeGrace

Francis H. DeGrace, M.D. who was born in 1907, died on April 19, 1969. He was a member of Loyola Medical School's class of 1934. Active in the affairs of the Passaic County Medical Society, he was an internist, affiliated with the medical department of Curtis Wright. Dr. DeGrace was identified with the field of industrial medicine and was a prominent figure in the New Jersey Industrial Medical Society.

Dr. Paul Dranow

One of the best known practitioners of North Essex, Paul Dranow died on May 14, 1969 at the age of 68. He was a family doctor of the old school, but took active part in the Academy of General Practice. Dr. Dranow was affiliated with both the Clara Maass Hospital in Belleville and St. Mary's Hospital in Passaic. He was a graduate of Boston University's Medical School where he received his degree in 1930.

Dr. Morton N. Fenster

Word has just been received of the death on January 20, 1969, of Morton N. Fenster, one of Passaic County's best known anesthetists. Dr. Fenster, born in 1904, was graduated from Bellevue in 1929. He was a general practitioner who had an early interest in anesthesia, and subsequently served as senior anesthetist at the Passaic Beth Israel Hospital.

Dr. Lester J. Finkle

Lester J. Finkle, M.D., died suddenly of a coronary attack on May 11, 1969, at the untimely age of 60. A graduate of the Jefferson Medical College, class of 1935, Dr. Finkle entered the field of internal medicine and became a Board Diplomate in that specialty. He was associated with the St. Francis Hospital in Trenton, and at the time of his death was chief of medicine. Dr. Finkle was a major in the medical corps of the U.S. Army during World War II, and was active in the affairs of the Mercer County Component Medical Society.

Dr. William S. Fithian

Bearer of a name written large in New Jersey medical history, William S. Fithian was killed in an automobile accident on June 6, 1969 at the untimely age of 46. He was a 1949 graduate of the College of Physicians and Surgeons of Columbia University and a well-known Cumberland County internist. Dr. Fithian was on the staffs of both the Bridgeton General and the Salem Memorial Hospital. He was an active member of our Cumberland County Medical Society.

Dr. Kurt F. Friedlander

Dr. Kurt F. Friedlander of East Orange, who was born in Germany in 1890 died in New Jersey on May 19, 1969. He was graduated at the Medical School of the University of Berlin in 1914. After he came to the United States, he established a general practice in Essex County and was invited to join the staffs of the Clara Maass Hospital in Belleville and the Beth Irsael Medical Center in Newark. Dr. Friedlander belonged to our Essex County Medical Society.

Dr. Bartley M. Howley

At the age of 58, Bartley M. Howley, M.D. of Highland Park, died on May 27, 1969. He

received his M.D. at the College of Physicians and Surgeons of Columbia University in 1937. After internship, Dr. Howley did graduate work and residency in otolaryngology and soon became a certified diplomate in that specialty. He was on the staff of the Middlesex General Hospital in New Brunswick and belonged to our Middlesex County Medical Society.

Dr. Harvey K. Mechanik

A 1940 graduate of the Jefferson Medical College, Harvey Mechanik died at the too-young age of 55. Dr. Mechanik, after a brief period of general practice, did graduate work in obstetics and gynecology and became certified as a board diplomate in both fields. He was especially well known for studies in gynecologic endocrinology. Dr. Mechanik was on the staff of the St. Barnabas Hospital in Livingston, and was an active Fellow of the American College of Obstetrics and Gynecology. He died after a brief illness on April 5, 1969.

Dr. Dean C. Moore

Word has just been received of the death in Marathon, Florida, of Dean C. Moore, M.D., a retired surgeon from Essex County. Although Dr. Moore died in 1968 (June 24), *The Journal* was not notified of his death until recently. He was a surgeon and gynecologist, and was 71 at the time of his death. He had been affiliated with the Orange Hospital Center and the East Orange General Hospital. During World War I, he entered the U.S. Navy as an ensign and was a full commander at the time of his demobilization, in 1918. He then entered Cornell Medical College and received his M.D. degree in 1922.

Dr. Berthold T. D. Schwarz

One of the country's best known physicians in the actuarial and insurance fields, Dr. Berthold T. D. Schwarz, died on June 20, 1969 at the age of 70. Dr. Schwarz was a graduate of the Medical College of New York University, class of 1924. Originally an internist, he became active in the field of life insurance and medical statistics, and during the last two decades was medical director of the Bankers National Life Insurance Company.

Dr. Schwarz was active in The Academy of Medicine of New Jersey, a national trustee of the American Cancer Society, a Fellow of the American Public Health Association, and a past lieutenant governor of the New Jersey District of Kiwanis International.

Dr. Harry Subin

Harry Subin, M.D., one of the best known and best loved medical figures in Atlantic County — a former president of his County Medical Society — died on April 7, 1969 at the age of 80. He was one of the first men in New Jersey to become board certified in surgery and was an early member of the prestigious Society of Surgeons of New Jersey, as well as a Fellow of the American College of Surgeons. He was a 1924 graduate of the Jefferson Medical College and, for many years, was an attending surgeon at the Atlantic City Hospital.

Dr. Henry Suesserman

His many friends were shocked on May 28, 1969, to learn of the unexpected death of Henry Suesserman, M.D. He won his M.D. at the medical faculty of St. Andrews University, in Scotland, in 1934. He was an attending internist at the Irvington General Hospital and was a board certified diplomate in that specialty. He was an internist with special training and skill in allergy. Dr. Suesserman was 64 at the time of his death. He belonged to our Essex County Medical Society.

Dr. Herman Weiss

Herman Weiss, M.D. was a well known Morris County internist. He was born in 1899 and received his medical degree in 1923 at the University of Frankfurt am Main in Germany. He had staff affiliations at both hospitals in Morristown and had his office in Dover. Dr. Weiss, for many years, was the senior internist on the consulting staff at the State Hospital in Greystone Park. He died on May 24, 1969, at the age of 70.

ANNOUNCEMENTS

Experimental Medicine And Surgery In Primates

A conference on experimental medicine and surgery in primates will be held September 7 to 12 under the sponsorship of the New York University School of Medicine. Cosponsors include the New York State Society of Medical Research and the Committee of Scientists for the Use of Primates in Medical Research. The program will be held at the Hunter College-Bellevue Department of Nursing Education, 1st Avenue and 26th Street, New York.

Here is a forum for discussion of the rapidly expanding medical research utilizing primate animals. The biologic resemblance between man and nonhuman primates gives investigators the advantage of accomplishing studies germane to human disease problems without risking human lives.

Sessions will deal with cross-circulation, transplantation immunology research, behavioral and neurologic studies, virology and infectious diseases, studies in fertility and birth control, research on the use of pregnant monkeys in investigating causes and prevention of birth defects, studies utilizing juvenile primate animals in investigations of growth and physical and mental development, utilizing of primate animals in teaching medical students, and reports from major primate laboratories in the U.S. and abroad.

For more details, write to J. Moor Jankowski, M.D. at the Department of Forensic Medicine, New York University, 550 First Avenue, New York 11016.

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital in Mount Holly announces a new series of presentations on the general topic of "Clinical Application of the Basic Sciences."

This is accepted by the AAGP with a credit of 1½ points per session. A star-studded faculty has been provided. The meetings are held on Thursdays at 3:30 p.m. in the T. J. Summey Building of the hospital.

The September series will cover intravenous nutrition on September 11; colitis on September 18; and gallbladder disorders on September 25.

Subsequent issues of this *Journal* will list the programs for the months following.

These lectures are supported by educational grants from Merck Sharp and Dohme, and The Burlington County Tuberculosis and Health Association.

For registration and further information, please contact J. R. Wolgamot, M.D., Director of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Congress On Occupational Health

The next Congress on Occupational Health will be held in St. Louis September 15 and 16. On the agenda are practical papers on air pollution, aviation medicine, radiation protection, whiplash injuries, hiring the disadvantaged, the role of the industrial nurse, and the measurement of impairment. For details, write to the Department of Occupational Health, American Medical Association, 535 North Dearborn Street, Chicago 60610.

Radiobiology Sourse

Columbia University announces a course in the Radiobiology of bones and joints, to be given Thursday evenings from September 18 through December 11. For more details, write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168th Street, New York 10032.

Radiobiology Course For Residents

An unusual course in the biology of radiology, including absorption, survival, dose-rate, radiosensitivity, autoradiography, and chromosome aberrations will be given at Columbia-Presbyterian Medical Center in New York for residents in radiology on twelve Wednesdays from 8 to 9 a.m., September 24 through December 17 (except December 3). The tuition is $50. For information and registration write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168th Street, New York 10032.

Hypnosis Course

Physicians may now take a course in basic medical hypnosis at Columbia University on Saturdays (September 27—November 8) from 10 a.m. to 5 p.m. Tuition is $175. The course is under the direction of Herbert Spiegel, M.D. For more details, write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168th Street, New York 10032. An advanced course, open only to *psychiatrists* who have taken the basic hypnosis course, will be given on four Saturdays during January, 1970. The fee for this series is $100.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969

September

10 **Academy of Medicine of New Jersey**
Symposium: "Organ Transplants"

10 **New Jersey Heart Association and New Jersey Department of Health**
Ocean County Community College
Toms River
Seminar on Stroke

11 **Burlington County Memorial Hospital**
Mount Holly
Principles of Total Intravenous Nutrition

17 **Academy of Medicine of New Jersey**
Symposium: "Diabetes Mellitus"

17 **Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
"A Clinic and Histopathologic Survey of Gynecology"

18 **Burlington County Memorial Hospital**
Mount Holly
Granulomatous and Ulcerative Colitis: Differential Diagnosis, Complications and Management

25 **Burlington County Memorial Hospital**
Mount Holly
The Diagnosis and Management of Some Common and Uncommon Gallbladder Conditions

October

2 **Burlington County Memorial Hospital**
Mount Holly
Mesenteric Vascular Insufficiency: Diagnosis and The Approach to Treatment

9 **Burlington County Memorial Hospital**
Mount Holly
Diseases of Intestinal Malabsorption

14 **Academy of Medicine of New Jersey**
Section on Dermatology and New Jersey Dermatological Society

15 **Academy of Medicine of New Jersey**
Symposium: "Interpretation and Control of Arrhythmias

15 **Academy of Medicine of New Jersey**
Section on Urology
Urology in Viet Nam

16 **Burlington County Memorial Hospital**
Mount Holly
The Differential Diagnosis of Jaundice

20-24 **Newark Beth Israel Medical Center and Academy of Medicine of New Jersey**
Newark Beth Israel Medical Center
Basic Vectorelectrocardiography

23 **Burlington County Memorial Hospital**
Mount Holly
Endocrine and Physiologic Sequelae of the Oral Contraceptives

25-26 **New Jersey Heart Association and New Jersey Regional Medical Program**
Atlantic City
Seminar on Coronary Care

30 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar: The Role of the Pastor in Death

November

5 **Academy of Medicine of New Jersey**
Symposium: "Controversies in Medicine"

6 **Academy of Medicine of New Jersey**
Symposium: "Infectious Diseases"

6 **Burlington County Memorial Hospital**
Mount Holly
Certain Gynecologic Disorders and Endocrine Management

12 **Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
"A Clinical and Histopathologic Survey of Gynecology"

13 **Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Morristown Memorial Hospital
Symposium: "Neuroblastoma in Children"

13 **Burlington County Memorial Hospital**
Mount Holly
Hematologic Problems in Pregnancy

19 **New Jersey Chapter, American Academy of Pediatrics**
Holiday Inn
Kennilworth
Seminar on Pediatric Allergy

19 **New Jersey State Dental Society**
Semiannual Session

20 **Burlington County Memorial Hospital**
Mount Holly
Microsurgery of the Ear

December

3 **Academy of Medicine of New Jersey**
"Symposium: "Shock"

4 **Burlington County Memorial Hospital**
Mount Holly
Parkinsonism: Assessment of New Therapeutic Modalities

11 **Burlington County Memorial Hospital**
Mount Holly
Common Allergic Emergencies

18 **Burlington County Memorial Hospital**
Mount Holly
Crisis Counseling

1970
January

7 **Academy of Medicine of New Jersey**
Symposium: "Immunology and Radiation Protection"

8 **Burlington County Memorial Hospital**
Mount Holly
Newer Anesthetic Agents

15 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Medical Management of Gastrointestinal Hemorrhage

22 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Gastrointestinal Hemorrhage

29 **Burlington County Memorial Hospital**
Mount Holly
Indications and Techniques for Urinary Diversionary Procedures

February

5 **Burlington County Memorial Hospital**
Mount Holly
Angiographic and Echographic Diagnosis of Genito-Urinary Lesions

11 **Academy of Medicine of New Jersey**
Symposium: "Isotopes and Recent Advances in Radiologic Diagnosis"

12 **Burlington County Memorial Hospital**
Mount Holly
Management of Chronic Renal Insufficiency

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Techniques

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society

12 **Academy of Medicine of New Jersey**
Symposium: "Pulmonary Embolism"

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

8 **Academy of Medicine of New Jersey**
Symposium: "Neurology"

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-20 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

27 **Academy of Medicine of New Jersey**
Annual Awards Dinner

BOOK REVIEWS

The Apologie and Treatise of Ambroise Paré. Edited by Geoffrey Keynes, M.D. New York, 1969, Dover Publications. Pp. 227 ($2.50)

Ambroise Paré dominated the surgical field during the 16th century. He turned from the blind following of other surgeons and also common practice to observation and thought as the foundation of therapy. The enormous breadth of his experience with battle injuries is shown by a sketch in the beginning of the book in which the man is wounded at all points by various weapons of war.

The "Apologie and Treatise," Part I of the volume, serves as a first hand report on the fifty most significant years of Paré's life. In it he, among other things, comments on the wisdom of using a ligature to secure hemostasis and also on the unwiseness of using boiling oil on open wounds. He recounts many experiences as a surgeon during the numerous military campaigns in which he participated.

Selected surgical writings such as discussion of hernia, wounds in general, cataracts, and the "How to Make Report" section, which is a fine comment on the technic of post-mortem examinations, make up Part II of the volume.

There are a number of fine pictures in the book. Curved and straight cutting edge needles with sutures are shown. The similarity to modern needles is striking.

Paré himself is shown in three engravings. The quiet dignity of the man is evident in the pictures of him at sixty-eight and seventy-two years of age.

The book is an unaltered and unabridged republication of the first edition prepared in 1952 by Sir Geoffrey Keynes. It is a handsome paperback and is of value for the personal library of surgeons and for all who are interested in medical history. It will serve in libraries in general as a basic historical volume in medical science and also as a prime source about the 16th century.

ROBERT K. SPIRO, M.D.

Cooking For Your Celiac Child. Charlotte Baum Sheedy and Norman Keifetz. New York, 1969, Dial Press. Pp. 244. ($5.95)

One author is a cookbook editor, the other a writer for a medical journal. Together they have prepared a fine book, helpful both to physicians and their celiac patients. Have you ever wondered about the derivation of the name celiac? It comes from the Greek "koilio," meaning abdomen. The text makes understanding of malnutrition syndromes easy; at the same time, the authors caution that gluten-free recipes are meant to be adapted to the individual patient under the care of his physician.

The therapist here gains an ease in the treatment of his patient. It is simple to verbalize the elimination of barley, rye, oats, and wheat from the diet of the celiac and sprue patient, but it is more difficult to tell him what exactly he *can* eat. These recipes make the patient feel "less different." Almost all foods that tickle the palate can be prepared gluten-free—such as ice cream, cookies, cake, and candy. This book tells you how. There is an ethnic flavor to the recipes also. Egg drop soup, gazpacho, chicken marsala, tamale pie, fluffy chocolate mousse, and saltimbocca are all saliva stimulating. One can be a celiac or sprue patient and still enjoy good eating.

This book of delicious recipes fills a void in the therapy of malnutrition syndromes. It belongs in the library of every physician and every individual who must live with these abnormalities.

HARVEY P. EINHORN, M.D.

Care of The Geriatric Patient, Ed. 3. Edited by E. V. Cowdry, Ph.D. St. Louis, 1968, Mosby. Pp. 430. Illustrations 19. ($15.75)

This is a collection of essays by different authors, specialists in medicine, surgery, cancer, religion, social service, rehabilitation, psychiatry, and so on. They seek to inform us about geriatric patients, their illnesses, problems, and care. Most of the cited references antedate 1953 and little material has been rewritten since the book's first edition in 1958. The subjects are much better dealt with in standard, modern textbooks where the doctor with questions will be safer and much better rewarded for his time.

The essays are either overlong, out-of-date, incorrect, or at best platitudinous

NORMAN RIFGEL, M.D.

The Mentally Abnormal Offender. Edited by A. V. deReuck and Ruth Porter. Boston, 1968, Little Brown. Pp. 260. (Price not stated)

In July 1967, the Ciba Foundation held a colloquium on the mentally abnormal offender. This volume is a transcript of the papers given and the discussion recorded at that symposium. Four of the essayists (Bittner, Diamond, Goldstein, and Watson) were American. The remaining 18 were British or Scandinavian plus one each from Belgium, Bulgaria, and Netherlands. The formal papers were followed by informal discussion, most of which is recorded here verbatim.

One gets a somewhat discouraging impression from a reading of the entire symposium. It is easy enough to calculate statistically the chance of a catatonic, a defective, a manic, or an obsessive-compulsive committing a crime next year. But this doesn't help us when we have to decide whether to release this specific patient at this time. If statistics indicate that there is a 90 per cent likelihood of his committing another violent crime, should we keep him locked up because that probability is too high? But if the chances are ten to one that he will not engage in violence, would it still be safe to release him, knowing that that one chance in ten might explode any day?

While the book offers no easy answers, it provides a thoughtful, often a wise approach to its problem, and is well worth the attention, the thought, and self-communion of anyone with responsibility for decision-making in his field. For a century, those of us in the behavior sciences—especially psychiatrists, social workers, and psychologists, have implied that if you turn over the offender to us, we have a better chance of remolding him than the prison guard has. It might be embarrassing if some day, some government, opened the doors to its prisons, invited us in and said: "Gentlemen, these are all yours. Show us how."

HENRY A. DAVIDSON, M.D.

Private Proprietary Medicine Stamps. Edited by G. B. Griffenhagen, R.PH. American Topical Association, Milwaukee, Wisconsin, 1968. Pp. 78. (Paperback $4)

Most of us are familiar with the revenue stamp you have to tear to open a fresh pack of playing cards. Compared to postage stamps, few collectors show interest in revenue stamps, yet they are a genuine part of our social history. It seems that in 1624, the Dutch Government offered a reward for "the invention of a new tax" (an activity these days which doesn't seem very difficult). Some enterprising Hollander suggested that they require stamps on all legal documents, declare unstamped documents invalid, and then watch the guilders roll in. Thus was born the revenue stamp. The British adopted the idea within a few decades, and the "stamp tax" played a dramatic role in colonial American history.

Since revenue stamps were equated with royal tyranny in the 18th century, the new-born U.S.A. government avoided them until the expense of the Civil War led to a search for new federal income. Thus, revenue stamps were printed by the U.S. Government as far back as 1862. The idea was to tax only items that were not really necessary to survival, and so the stamps were put on cosmetics, playing cards, and proprietary ("patent") medicines.

During the 19th century, American patent medicines were wild and woolly. Just reading the labels on some of their bottles is a fascinating exercise in cultural history. Some companies then got another bright idea. They would print their own revenue stamps, save the U.S. Government the cost of printing, and then run a little advertising on the stamp. And that is what this booklet is all about. It lists the proprietaries in alphabetical order from Arnold's 19th century cough killer and anti-bilious pills, through Branca's Bitters (1869), Crittenton's Honey and Horehound (1860), Drake's Plantation Toddy (1870), Hazeltine's 1878 Cure for Consumption, and so on, to Winslow's Soothing Syrup. While $4 seems a bit high for a 78 page paperbound book, this one is profusely illustrated with several hundred pictures of stamps and advertising posters. You can hardly call this book a "must" for the doctor's library, but it is an interesting presentation and makes us feel that we have made much progress in the last century. Or have we? JOSEPH L. BARONE, M.D.

Pediatric Cardiology. Edited by Hamish Watson, M.D. St. Louis, 1968, Mosby. Pp. 996 ($36.50)

This is a magnificent volume, in spite of the high cost figure which induces a form of shock not treated within its pages. Watson has here collected an international coterie of experts including Rudolph, Neill, McNamara, Kaplan, Braunwald, Los, Bossina, Walker, Engle, Walsh, and others, and has edited the contributions beautifully while translating all material into Scottish English. It is, however, a bit unnerving to read Texan Dr. Denton Cooley writing about "Haemodilution, Oesophageal, and Paediatric" problems.

Since the shelves of my medical bookstore now contain six large and expensive volumes on the subject of pediatric cardiology, all written recently, one wonders at the justification for yet another publication. I will not compare these volumes except to say that I prefer an edited anthology to the single author volume and that I found this book by Dr. Watson particularly clear and well written.

Since receiving this text for review I have looked up answers to the following problems occurring in the course of a general pediatric practice. This approach to my review is intended to indicate that I found the text of great value.

On page 891, I found the dose of digoxin given in milligrams per kilogram while on page 905 of the same chapter I found the dose of acetazolamide given in milligrams per pound.

On page 211 one reads that good results can be expected from surgical repair of isolated coarctation at the appropriate age. The appropriate age, however, is not suggested.

The indications for surgical closure of ventricular septal defects seem quite reasonable, including large shunts, congestive heart failure, and failure to thrive. The discussion of spontaneous closure of ventricular septal defects is good.

I was disappointed in not finding a discussion on marital advice to be given to adolescents with congenital cardiac disease in the chapter on social aspects. This may be due, however, to narrower age limits implied by the term pediatric in some parts of the world.

The foreword was written by Dr. Helen Taussig whose own book is a classic in the field.

SOLOMON J. COHEN, M.D.

Introduction to Medical Science. Clara G. Young and J. D. Barger, M.D. St. Louis, 1969, Mosby. Pp. 294. Illustrated. ($7.95)

It's about time someone offered a book like this. It is a combination text book and self-administered quiz manual for technicians, medical secretaries, nurses, physical therapists, and other paramedical personnel. Each chapter opens with sound textual material, whether dealing with clinical concepts like epilepsy or heart disease or fundamental preclinical material like inflammation, metabolism or repair of injured tissue. Most chapters also include self-administered examinations with the answers in the back of the book. While the book does not try to make physicians, junior grade, out of its readers, it does avoid the sin of talking down to intelligent readers. It's a good office manual or Christmas present for the staff of any doctor. VICTOR HUBERMAN, M.D.

Pictorial History of Psychology and Psychiatry. A. A. Roback and Thomas Kiernan. Pp. 294. Profusely illustrated. New York, 1969, The Philosophical Library. ($12.50)

In this atlas, the compilers present a brief accounting of the great names in the history of psychology, and, in somewhat shorter compass, the history of psychiatry. Most of the people mentioned are shown by photographs with concise biographic accounts. Many of the historical threads in psychology are traced in narrative fashion. The editors seem obsessed with the female breast, and this is portrayed on all kinds of pictures and for all kinds of reasons — to illustrate exhibitionism, to show Catherine the Great (characterized as the nymphomaniac on the throne), to exemplify narcissism, to show witches riding bare-breasted on goats, in pictures of Aphrodite and Cleopatra, to accompany a text on the women of the *Kama Sutra*, and a gallery of camp followers and courtesans. The text is a bit heavy on the side of experimental and clinical psychology, and gives a once over lightly to psychiatry and the medical phases of the problem. WILLIAM SCHRAM, M.D.



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REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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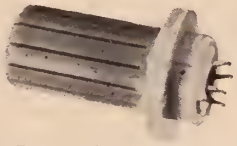
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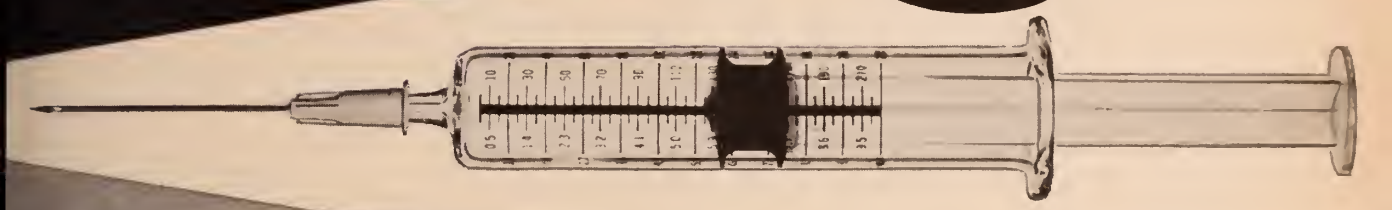
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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

SUBSCRIPTION RATES — Price per year in advance, including postage: United States, $5. Foreign, $5, plus postage.

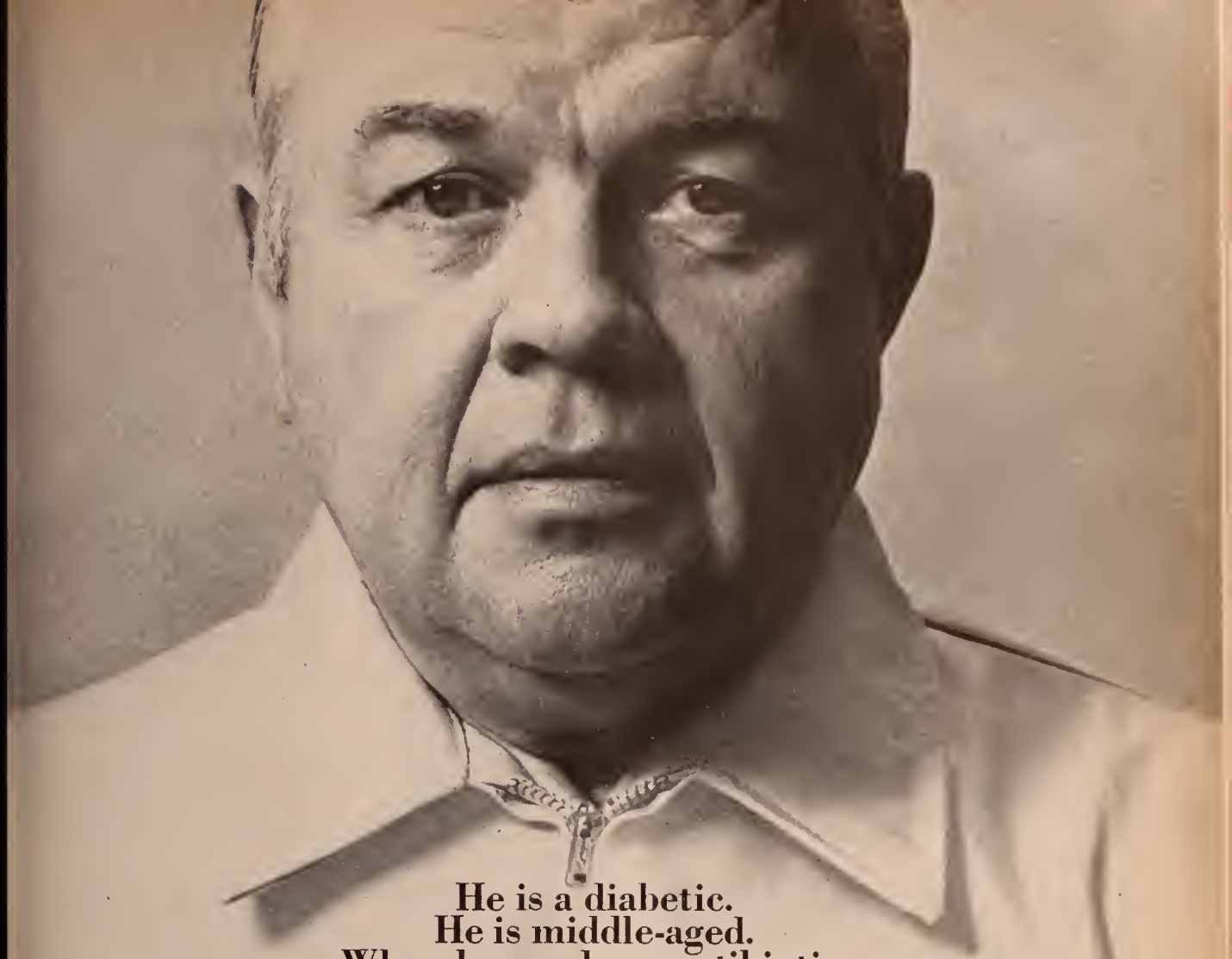
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ropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
oscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
enobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

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Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



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Hard to believe... a natural beauty spot like this... within easy weekend commuting distance. But it's here atop the Pocono Mountains. A 2½-mile long private lake, undisturbed by power boating, set in 20,000 wooded acres.

Recreational living at its finest. $150,000 private Lake Naomi Club with teen center, ballroom, cocktail lounge, and dining room overlooking the lake. Great sailing, fishing, horseback riding. Four sand beaches with lifeguards. Championship Pocono Manor golf courses at your doorstep, also famous Camelback ski area. Scheduled airline service, Mt. Pocono Airport only 3 miles from the lake.

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it's time that
you discovered
LAKE NAOMI
the incomparable
second-home retreat

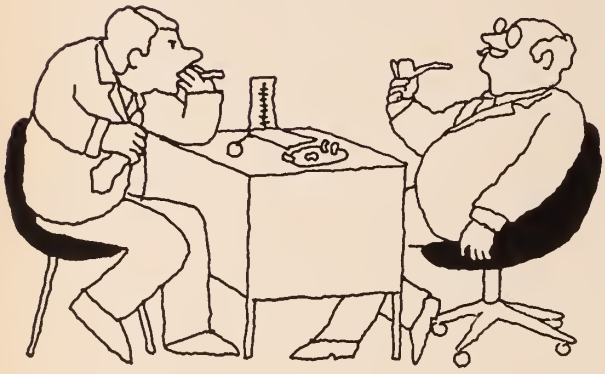


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Box 188, Pocono Pines, Pa. Phone 717-646-2222

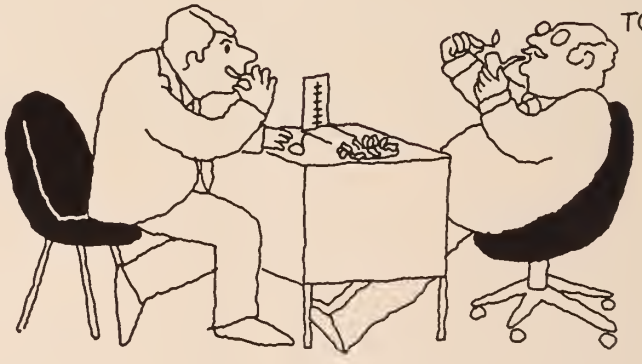
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The Apprehensive Hypertensive



WELL, YOU HAVE WHAT WE CALL MODERATE HYPERTENSION— HIGH BLOOD PRESSURE. NOW I DON'T WANT YOU TO WORRY, BUT WE ARE GOING TO HAVE TO CHANGE A FEW LIVING HABITS. FIRST, WE'RE GOING TO HAVE TO CUT OUT SMOKING—ALTOGETHER.

THEN WE HAVE TO LOSE WEIGHT. 20 POUNDS SHOULD DO IT... WE'LL TALK A LITTL LATER ABOUT THIS DIET WE'RE GOING TO START.

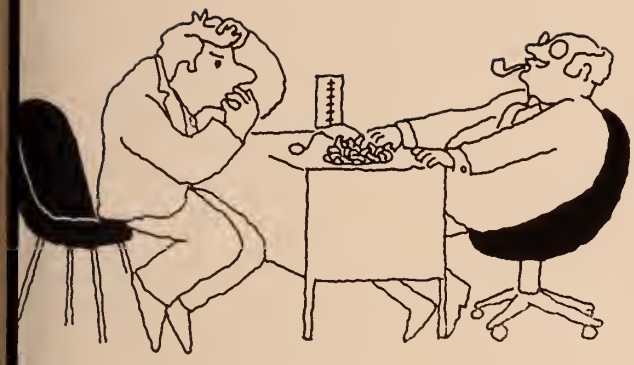


Regroton® to lower blood pressur

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Incr respiratory secretions, nasal congestion, cyanosis and anorexi occur in infants born to reserpine-treated mothers. *Precautions:* A pertensive therapy with this drug should always be initiated caut in postsympathectomy patients and in patients receiving gang blocking agents, other potent antihypertensive drugs, or curare. R dosage of concomitant antihypertensive agents by at least one-h avoid hypotension during surgery, discontinue therapy with this two weeks prior to elective surgical procedures. In emergency su use, if needed, anticholinergic or adrenergic drugs or other supp measures as indicated. Because of the possibility of progress renal damage, periodic kidney function tests are indicated. Disco if the BUN rises or liver dysfunction is aggravated. Hepatic com be precipitated. Electrolyte imbalance, sodium and/or potassiu pletion may occur. If potassium depletion should occur during th the drug should be discontinued and potassium supplements provided the patient does not have marked oliguria. Take particul in cirrhosis or severe ischemic heart disease and in patients rec

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.





and allay anxiety in hypertension

rticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

Include MILK *in your* LOW-SALT DIETS

It's no longer necessary to deny patients fresh, fluid palatable Milk in low-salt diets. Walker-Gordon fresh Lo-Sodium Milk (Certified Milk with 90% of Sodium removed) contains less than 50 mg. Sodium per quart. *Guaranteed free of antibiotic residue.* Paper half-pints for hospitals, quart bottles for home delivery. Write or phone for literature, low-sodium diet sheets, and professional sample.

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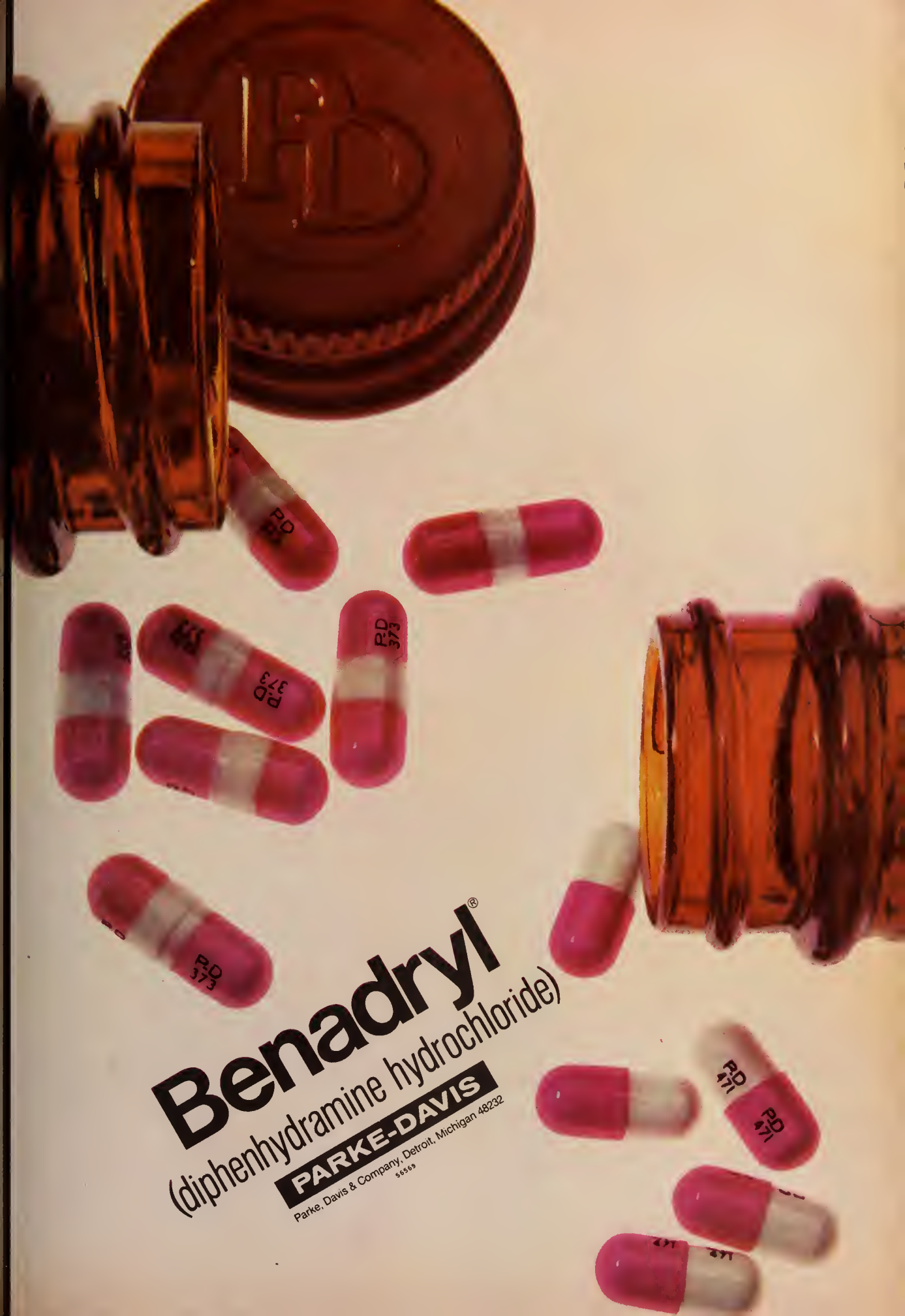
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now he can cope...



thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

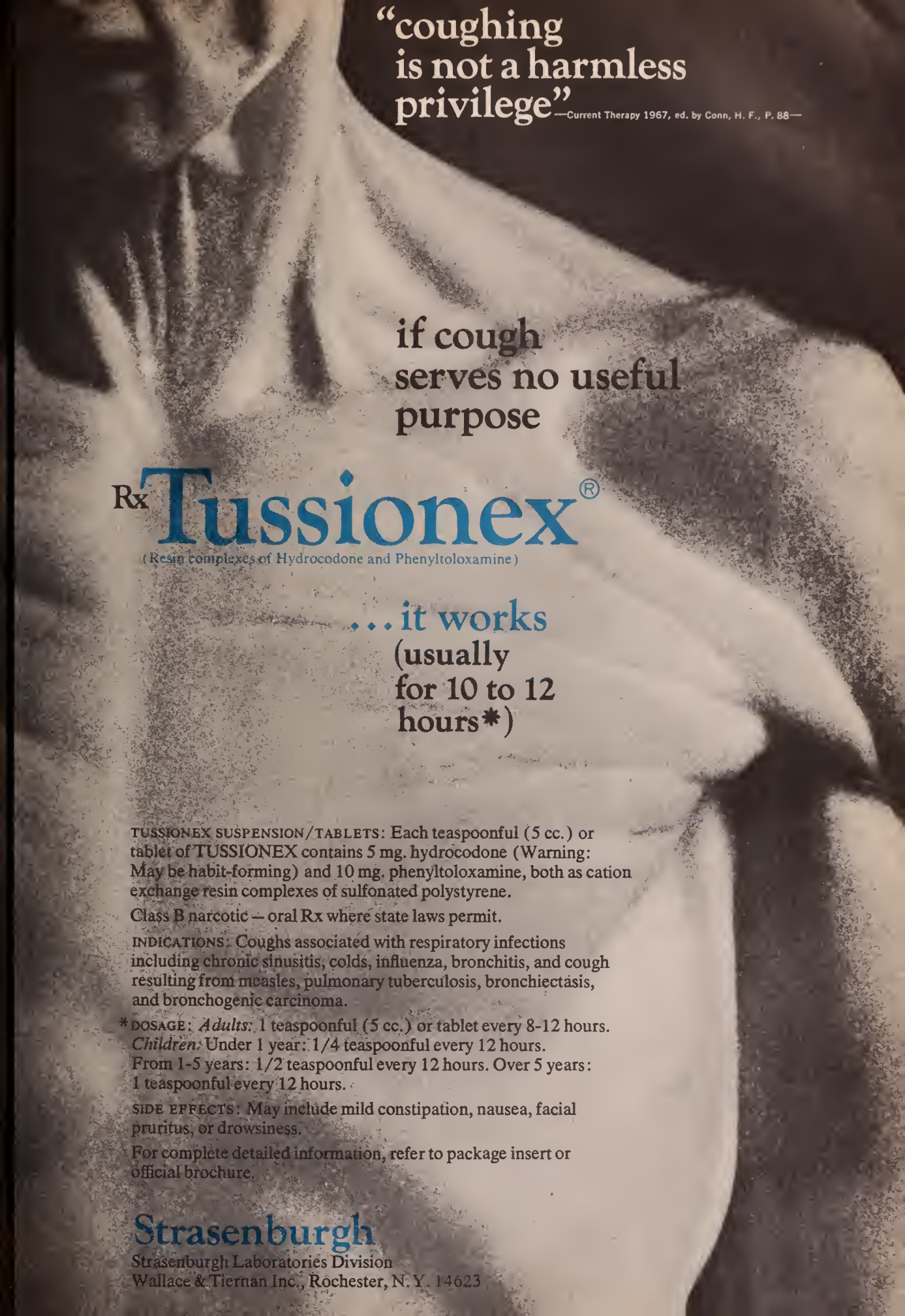
Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623



No place for beginners

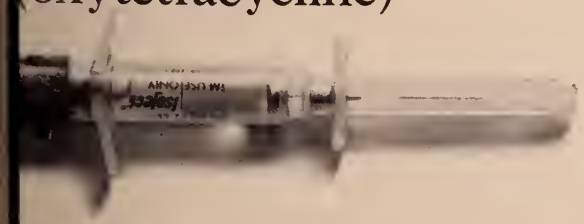
Terramycin®
oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis. In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

Symbols in a life of psychic tension

M.A.

class of '66

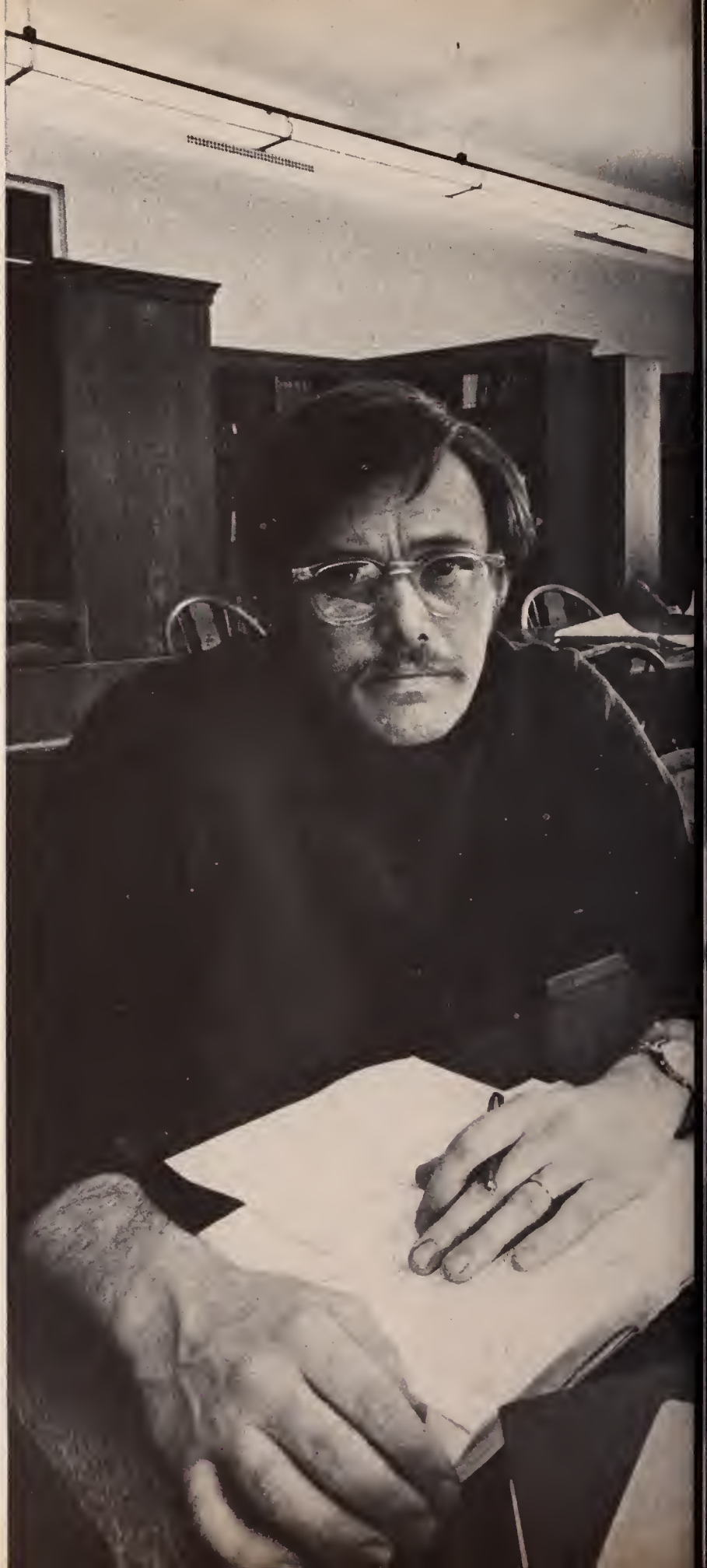
Ph.D.

thesis...in progress

G.I.

series and complete examination normal

(persistent indigestion)



ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

M. A. (class of '66)...Ph.D. (thesis, in progress)...letters that represent a young lifetime of work...a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish...a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an *h.s.* dose added to the *t.i.d.* schedule.

Valium is generally well tolerated. In proper maintenance dosage it seldom dulls the senses or interferes with functioning. Side effects most commonly reported have been drowsiness, fatigue and ataxia.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets
to help relieve psychic tension
and its somatic symptoms



Dear Doctor, You made me what I am today - a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report describes T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/69

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



symptoms of mixed anxiety-depression are rarely clear-cu

but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69 384



an antibiotic you can use without risk to the kidney

Polycillin-N®

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

RESCRIBING INFORMATION. 11—1/2/69. For complete in-ormation consult Official Package Circular.

ndications: Infections due to susceptible strains of Gram-egative bacteria (including Shigellae, *S. typhosa* and other almonellae, *E. coli, H. influenzae, P. mirabilis, N. gonor-hoeae* and *N. meningitidis*) and Gram-positive bacteria (in-luding streptococci, pneumococci and nonpenicillinase-pro-ucing staphylococci).

ontraindications: A history of allergic reactions to penicillins r cephalosporins and infections due to penicillinase-produc-ng organisms.

recautions: Typical penicillin-allergic reactions may occur, specially in hypersensitive patients. Mycotic or bacterial su-erinfections may occur. Experience in newborn and prema-ure infants is limited and caution should be used in treatment, ith frequent organ function evaluations. Safety for use in regnancy is not established. In gonorrheal therapy, serologic sts for syphilis should be performed initially and monthly for months. Assess renal, hepatic and hematopoietic function ntermittently during long-term therapy.

dverse Reactions: Skin rash, pruritus, urticaria, nausea, vom-ing, diarrhea and anaphylactic reactions. Mild transient ele-ations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

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Contraindications: Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy.
Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn.
Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of monilia sis may occur.
Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "we

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lasting Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

[illegible] urticaria, flushing, dryness of the mouth, [illegible]a or vulva, vaginal burning, pruritus, dysuria, [illegible], a sense of pelvic pressure, dyspareunia, [illegible], polyuria, incontinence, decrease of libido, [illegible] congestion, proctitis, pyuria and darkened [illegible] have occurred in patients receiving the drug. [illegible]nts receiving Flagyl may experience abdominal [illegible]s, nausea, vomiting or headache if alcoholic [illegible]rages are consumed. The taste of alcoholic [illegible]rages may also be modified.

[illegible]ge and Administration: In the Female. One [illegible] mg. tablet orally three times daily for ten days. [illegible]s may be repeated if required in especially [illegible]rn cases; in such patients an interval of four [illegible] weeks between courses and total and differ[illegible] leukocyte counts before, during and after [illegible]eatment are recommended. Vaginal inserts of [illegible] mg. are available for use, particularly in stub[illegible] cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the *oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the *sole* form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

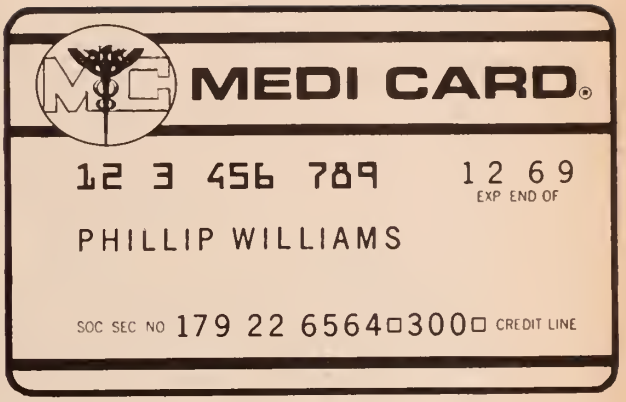
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EDITORIALS

Thanatology

As usual, the Greeks had a word for it: thanatology. This means the scientific study of death and the handling of problems of grief and bereavement. Since the doctor traditionally considers death as his number one enemy, there is a certain logic in this interest in looking at the enemy in the face. For better or for worse, the physician is one usually in at the death. Legally, indeed, he is the only one who can "pronounce a person dead" (a strange phrase, is it not?). If he is, as he should be, looked to as the one who can console the family during the penultimate act, why should he not be relied on to take the sharp edge off a family's grief? Too often, the doctor quietly tiptoes out, mumbling perhaps a perfunctory, "Well, we did all we could." Actually, it is not callousness or shame which makes the physician want to escape from the death bed. It is simply that most of us have not given any in-depth thought to the problem. How do you deal with the dying patient who wants to know? What can you say to bereaved relatives?

And so, and at long last, a special organization has been created to review this. Called *The Foundation of Thanatology* (See page 542, this issue), it is perhaps the first serious and scientific organization to study this matter. You can get more information about it from Austin H. Krutscher, M.D., at Columbia Presbyterian Medical Center, 300 West 168 Street, New York City 10032. They have an interesting and helpful reading list already compiled.

Let's face it. Most of us just don't want to face it. We say we are more concerned with keeping people alive than with easing their passage across the Styx. Yet, this is a legitimate function for the physician; and so is the care of the bereaved. It is about time our profession did something to think through these problems.

What Puts The Tension In Hypertension?

Why do they say that the good die young? Presumably it is because a good person has a conscience, a bad person doesn't. You cannot have anxiety unless you have a conscience. A good doctor worries about his patients, a good business man worries about the quality of the goods he sells, a good friend worries about *your* troubles. So the good worry and develop anxiety.

Fortunately it is not quite like that. The bad person has tension too — not the pricking of conscience but the hungry drives of hatred and hostility. The malignant emotions are not sympathetic worries, but rather the need to win, to dominate, to vanquish. These are potentially destructive drives. And here is a destroying, self-eating, corrosive tension. This is a tension that goes readily into hypertension.

But there's more to it than that. Every muscle contraction is a potential contributor to hypertension. To contract a muscle you need glycogen and oxygen. And when the fiber contracts it produces pyruvic acid and creatinine, lactic acid and carbon dioxide. These waste products have to be transported from the muscle for disposal elsewhere.

There is no escape from constant muscle contraction. Life cannot long exist in a state of muscular flabbiness. Perhaps though, we can learn — and then teach — how to relax our musculature between necessary stresses, how to cut down the pressure of competition, and how to provide benign outlets for hostility. To suppress hostility is no help, since the damming back of this will send the blood pressure up. The goal is to feel no hostility. One who can honestly develop an attitude of "I'm not mad at anybody" is a good insurance risk. The final cure will surely come not in medication or surgery but in learning a happier pace of life.

And then the hateful man will die young. The good will survive.

The Underprivileged Male

In terms of longevity males seem to be an underprivileged segment of the population. Not only do women live longer than men, but the gap is getting greater. Last year the death rate for males was 50 per cent higher than that for females.

This is due in part to medical progress. In primitive countries women have a higher death rate because of the dangers of childbirth. In countries like ours, where the obstetrical hazards are minimized, men consistently have a higher death rate. Cancer is about one-fifth more common as a cause of death in men than women in spite of the frequency of cancer of the breast and uterus. It seems that malignancies of the pulmonary, gastro-intestinal, and genito-urinary tracts are more common or more rapidly fatal. Accidents, of course are more common among men than among women.

Whatever the cause, the fact is that women live longer. In spite of the fact that they live longer they appear to have more illnesses. This statistic is derived from reports of clinics, doctors, and hospitals. It may mean merely that women are more willing to consult a doctor when they feel sick.

This last item might suggest that one reason for the male's unfavorable position here is his own unwillingness to seek medical attention in good time. The "See your doctor twice a year" advice has some real meaning after all. Physicians might follow it too.

Competition In The Drug Industry

More than 1,000 pharmaceutical companies manufacture drugs for our use. That means a lot of competition, jostling, and duplication. Theoretically, it would seem smarter to consolidate these companies into a single drug-making unit that would save millions in overlapping costs and avoid duplication of effort. Yet if this were ever done, it would be a massive blow to public health. The competitiveness of the drug industry—which is a drag on the industry's profits—is a boon to our patients and to ourselves.

The most dramatic effect of this competition is the way it keeps prices down. With all good companies making drugs that conform to standard, no one is going to buy Tradename X at 4 cents a capsule when Tradename Z sells at 2½ cents. So competition forces down the price, benefiting our patients. More than that, competition compels companies to search for different and better ways of preparing an item. If Company A has a patent on a process, Company B cannot get into the act unless its chemists find an equally good but basically different process. So competition spurs Company B's efforts to improve the technic; and Company A, anxious to remain in the running, redoubles its efforts. Then, too, competition rapidly makes drugs obsolete. If one manufacturer produces a fine antibiotic with only three side-effects, his competitor works to manufacture one with no side-effects. Result: the first antibiotic becomes as obsolete as tincture of gentian. This plays havoc with drug profits but it keeps the best pharmaceuticals in front of the shelves.

Every good company competes with itself. One chemist sweats for years to manufacture a new drug only to see his colleague across the room make it obsolete by finding a better product. Then, too, competition prevents a company from becoming self-satisfied. No pharmaceutical manufacturer can ever rest on his oars.

So let Europe have its cartels, and Russia its state monopoly. We'll take a thousand fiercely competitive companies duplicating each other's efforts, driving each other's prices down, and striving mightily to win the blue ribbon for the most effective, least toxic drug of its kind. It is no coincidence that competitive American drug enterprise has given us the finest pharmaceuticals in the world.

ORIGINAL ARTICLES

The identity crisis is much talked about these days. The disadvantaged adolescent suffers from a double crisis in this area.

The Disadvantaged Adolescent*

A Psychodynamic Evaluation

Frederick J. Wertz, M.D./Fort Lee

The challenge of the disadvantaged adolescent is a striking example of the need to use the tools of sciences other than psychiatry in understanding the adolescent's personality development. Many of the source references for this paper are in the fields of sociology and education.

To understand the adolescent, or any other age group for that matter, one must go to the roots of family structure and parental influence. This does not gainsay the effects of sociologic forces, such as poverty, unemployment, lack of educational opportunity, and so on. But, keep in mind that society in general and the society of the disadvantaged adolescent in particular are composed of the family unit, and from the family emerges the individual.

Community life fosters mental health in some community members and mental illness in others. Simmons[1] emphasizes three levels on which one may evaluate personality adjustment: "(1) as an organism in a physical environment striving to survive (this would include the problems incurred by physical illness as well, and the capacity of the individual to resist such onslaughts); (2) as an individual member in a society (community) endeavoring to relate successfully and to belong securely; (3) as a person in a culture shaping his personality more or less to a conventional model, the man as he *should* be." Simmons[1] explains that a community develops a life style essentially from its cultural pattern and its structured relationships. These influence how the individual members "behave, think, and feel" and determine how successful they are as well as the degree of maladjustment in their personality make-up.

Purcell and Hillson[2] note that in a study on 5,000 aid-to-dependent-children families, the school drop-out rate was very high and the school retardation rate doubled that of the national average. The possibility of these children being employed in satisfying, meaningful work as adults was rather dim. Moreover, their welfare status with its cultural pattern and the model for emulation it offers, referred to by Simmons,[1] has produced not only a second generation of aid-to-dependent-children families but, at present, is well on its way to producing a third generation.

The same authors emphasize the role of "social class" in low-income groups that discourages educational motivation. The value system of such a class is geared to the satisfactions of the immediate present. This is directly opposed to an educational value system where the structure is designed for long-term satisfactions and distant goals. The ever present demands of the basics of food, clothing, and shelter are too anxiety—provoking to permit tolerance of a system that advocates nebulous and distant gratification. They cite a study by Keller[3] on the effect of slum living on intellectual functioning. Her findings revealed a drop in IQ scores of eight points from the first to the fifth

* Read before the Section on Psychiatry and Neurology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969.

grade. When the child reached the fifth grade, he was already two years retarded in reading.

The educational handicaps implicit in such a socio-cultural matrix have been highlighted recently by the Head Start programs.[4] The study requested by the Office of Economic Opportunity indicated that "poor children have been so badly damaged in infancy by their lower-class environment that Head Start cannot make much difference." Of particular significance in connection with the effect of emotional factors on intellectual functioning was the conclusion of the researchers that "The improvement of the child's emotional and social development is one of the major goals of Head Start. . . . However, the findings of this study show that affective development . . . has not been improved by either full-year or summer programs."

A study by Stein[5] on adolescent adjustment within different ethnic groups — Italian and Irish — revealed that attitudes and values within the family leave the adolescent with what she refers to as "a different heritage of thinking style and behavior patterns" differing in direct proportion to the differences in ethnic families. She describes the Irish adolescent as having egocentric, closely knit patterns in the service of conformity, whereas the Italian's self-image was directed more to overt manipulations of the social environment and governed by the sociocentric ideology of the parents.

Keller[3] observed that there is less personal interaction by low-income children with their parents. Activities which involve all family members are uncommon. She equates this lack of parental affective contact with the below IQ scores these children manifest by the fifth grade, their demeaning self-evaluation when they compare themselves with other children, and their low self-esteem which is contrasted with their high vocational aspirations, so often frustrating in itself, since they are seldom achieved.

Lest we move too far away from psychiatric concepts, we are reminded of the effect of family on childhood psychoses by McDermott, *et al.*[6] This group reviewed 627 patients with a diagnosis of psychosis. The incidence was not significant among the five social classes represented. Of significance, however, was the *manner* in which the psychosis was given expression. This was dictated by the family styles and the customs of child-rearing. Sandhu[7] found that the perception of parents rather than that of race and class was a more significant factor in gang delinquency and academic performance. Non-conventional parents were equated with a higher rate of delinquency and lower marks; conventional parents were equated with a lower rate of delinquency and higher marks.

Is it the cultural and societal forces that mold the individual or is it the intrapsychic conflicts in his parents, created by instinctual drives, which distort the adolescent's reality? Actually, one need not be forced into such a dichotomous appraisal. There is ample room for the influence of both cultural and social forces and intrapsychic drives that exist independent of the environment. It is useless and enervating to argue which exerts a primary force. They combine their effects in molding personality development. This combination has a rhythm and a style based on the interaction of environmental forces and intrapsychic drives in whatever degree is dictated by both the particular society under scrutiny and the genetic endowment of the individual member of that society. For purposes of refreshing clarification, I wish to present clinical material. The cases offered are those of a girl and a boy.

The Case of Ruth

Ruth, now 18 years old, is the fifth of seven children, three brothers and three sisters. Her two older brothers, her oldest sister and she are the products of the same marriage. The oldest child, John, was an out-of-wedlock child from a different father. Ruth's mother married her father while she was pregnant with John. The two youngest girls are the products of different paternities. The older one, Joan, was also an out-of-wedlock child born after Ruth's mother had divorced her father. The youngest girl was the issue of Ruth's mother's present husband to whom she has been married for several years.

Ruth's mother lived with her own parents and five siblings until she was eight years old. Because her parents were considered "unfit," she was place in an

orphanage until she was 12 and then in another institution until she was 16. She returned to her own mother who was described as "untidy, a hillbilly." Two years after Ruth's mother returned home, her father, who had been living in a common-law relationship with her mother, deserted them. He met a young girl of 23 and married her. Ruth's mother, shortly thereafter, became pregnant with Ruth's oldest half-brother and then married Ruth's father at 18 years.

Ruth's father was a poor provider. He abused Ruth's mother and showed increasing signs of mental disturbance. When Ruth was three years old, he was in a state hospital for three months and discharged with a diagnosis of psychosis with sociopathic features.

The marital relationship became increasingly unstable. Ruth's father accused her mother of infidelity and denied paternity of his four children. The children were exposed to hardship and neglect. They were physically abused by their parents. Ruth's father eventually disappeared. Ruth's mother then lived with another man bearing Ruth's younger half-sister, Joan. The Court judged the children neglected and placed them in foster homes. Shortly before placement, the oldest child, John, at age 9, died in a fire he had set himself while his mother was shopping with the other children.

After an initial placement of 11 months, Ruth, at the age of 4 years, 7 months, was placed in a second foster home in which she remained until 17½ years when she returned to live with her mother and her stepfather. Several months before Ruth rejoined her mother, the youngest half-sibling, a girl, was born.

At age five, because of overt anxiety which she rigidly attempted to control, she was referred for psychiatric evaluation. The impression was a serious personality disorder with constricted affect and controlled feelings. She underwent psychotherapy for a year. Treatment was suspended at age seven because of minimal progress. It was felt that her foster home provided her with the kind of structure and control that strengthened her obsessional defenses and maintained her personality intact. Her rigidity was concealed by a facade of compliance and "sweetness." A psychotic process beneath this facade was suspected.

Ruth, when nine years, continued to remain a constricted child with intellectual control of her emotions. Her fantasy life revealed a strong desire to achieve unity with her own mother and her siblings several of whom had been reunited with her mother. She was subject to various fears and suffered from a mild subway phobia. She was wary of her environment suggesting a somewhat paranoid orientation. Her school progress and foster-home adjustment were considered satisfactory.

Ruth was evaluated again at 11½ years. She continued conflicted and ambivalent over living with her mother. Her ambivalence was such that it was recommended she remain in her foster home until her mid-teens. She was detached from her environment and mild paranoid features continued to be present. She had begun to express indifference to school work with academic achievement much lower than her IQ of 122 should have produced. Her foster home, although satisfactory in terms of offering her structure and support, was not a home in which broad interests and intellectual curiosity were stressed. The importance of education was not emphasized. Both foster parents' educational background was limited.

When Ruth was 17, she suffered a depression that resulted from feelings of rejection, particularly by her real mother, but also by her current boyfriend. She was immature for her years speaking in "a little girl voice." At this time and for several years, she had been the only child not living with her natural mother. School achievement was poor despite a continued above-average IQ. In contrast to her intelligence, Ruth spoke ungrammatically with a limited vocabulary. Vocational aspirations, despite a real talent in art, were confused. She expressed strong feelings of inadequacy and lacked self-confidence and an independent drive. She was severely self-critical of both her physical appearance and her general functioning. Psychotherapy was recommended with some improvement achieved.

Shortly thereafter, Ruth returned to live with her natural mother, one of her brothers and her two half-sisters, Joan, now 14, and the new baby, eight months of age. Adjustment was extremely difficult and never satisfactorily achieved. Ruth's desire to possess her mother completely was so great that it provoked endless quarrelling and dissatisfaction between them. Her rivalry with Joan was intense, based on a rivalry for mother's affection. School performance worsened. Finally Ruth was unable to resolve her fantasied image of the loving mother with that of the mother in reality. Shortly after her 18th birthday, she returned to her foster parents, enrolled in her original high school and, at present, has begun a drive for independence from her foster family which is fraught with anxiety and many self-doubts. On the whole, some improvement has been noted.

The Case of John

John, now 14½ is the younger of two boys. His brother, Edward, 15½ years, was his codefendant in a breaking, entering, and larceny charge which brought both into juvenile court one year ago. Prior to that, there had been a number of antisocial acts dating from 11½ years; these included throwing rocks at streetlights, setting fires, and stealing.

John was born in New York. Developmental milestones were within normal limits, and the pre-school years, according to his parents, were uneventful. (This kind of early benign history is one often obtained when psychopathology in the later years makes its appearance; it is always highly questionable.)

His father, a postman, was orphaned at an early age and, with his three brothers, was placed in an institution until he was 16. He then had a series of jobs including two years in the Army before marrying John's mother. He is rough in manner and is flashily dressed in keeping with his narcissistic character structure which has led him to spend many hours away from home with a local drama group. He has divorced himself almost completely from involvement with the family, blaming his wife for John's difficulties. When he does exert his influence, he is very punitive, usually physically, with the boys and displays a violent temper. On the whole, he is ineffectual. He and his wife quarrel about the degree of responsibility each feels the other should assume. John's father manifests little anxiety or guilt over his inconsistent, indifferent attitudes toward his family. His living pattern suggests a sociopathic personality structure. This is exemplified by his coaching John on one occasion in a method by which he could extract quarters from a vending machine. His wish is that John would "grow out" of his difficulties.

John's mother suffered the loss of her own mother at nine years. She and her brother were placed by her father who was unable to care for them. He was an inadequate individual, living on welfare. She is an

overly anxious woman, hostile and rejecting of John, openly comparing him unfavorably with his older brother. She is manipulative and coercive, using John as a source of anxiety release by displacing her own and the family's problems onto him. She has talked of placing the boys in order to resolve her difficulties. She is unable to follow through on disciplinary measures and is easily manipulated by John and his brother. John's mother was married and divorced prior to her marriage to his father. She had one daughter from this union, whose care she almost completely relegated to her own mother.

Money has always been a problem in the family. The father works in another capacity when his duties as a postman are completed. This additional work absents him further from the home. The mother also has worked both full-time and part-time for many years delegating the care of the boys to neighbors or simply leaving them after school unsupervised. Their home has been found to be disorganized, untidy, and inadequately maintained.

John's school record is poor. Now in the ninth grade, he is failing several subjects with marginal marks in the others. His intelligence on formal testing, 113, is above average in contrast to his reading ability which is one year below grade and his arithmetic ability, three years below grade. From the early grades, his behavior has been disruptive, aggressive, and basically contains an acting-out pattern. His relations with teachers and peers are characterized by defiance. He has little interest in academic achievement and is withdrawn and indifferent to teaching unless constantly supervised. He is not accepted by his peer group and externalizes his problems to his environment.

His mother describes him as mischievous, aggressive, insolent, and rebellious. He is fearful and anxious, feeling inadequate in many situations. Example: He refused to attend Little League tryouts for fear of not being chosen. He feels rejected by both parents, particularly the mother. He is frequently depressed with various somatic complaints. In the past he resolved hostile feelings by withdrawal, but recently he has begun to act-out his anger in the neighborhood by anti-social acts frequently directed against authority figures.

These two cases demonstrate the unhealthy effect that inimical social and family factors have on the intrapsychic development of the adolescent. Of paramount importance in evaluating adolescent behavior is a study of the environmental forces operating during the pre-school years and the elementary school years. The pre-school period is perhaps the more important. Van Ophuijsen[8] clarified the dynamics of conduct disorders which are the forerunners of aggressive, acting-out behavior in later years. He viewed them as a reaction to environmental forces that eventually became persistent behavior patterns. He chronologically placed their onset "at three years or before" and related them to unresolved oedipal conflicts of varying intensity. The adolescent is the sum total of his infant and childhood experiences. In trying to understand the behavior of the adolescent, we must not only analyze his current functioning, but we must also analyze the emotional interchanges, the environmental influences he has been exposed to in the earlier years.

Erikson[9, 10] has written of the various aspects of identity, national and individual, with some emphasis on the identity confusion or "identity crisis" of the adolescent. He quotes[10] Biff's statement in Arthur Miller's *Death of a Salesman* as exemplary of identity confusion: "I just can't take hold, Mom; I can't take hold of some kind of life." He relates many of the emotional disturbances of adolescence to ". . . a dilemma . . . based on a strong previous doubt of one's ethnic and sexual identity, or where role confusion joins a hopelessness of long standing. . . "

Of all the mental mechanisms used in coping with daily life experiences, identification is one of the most important. Identification with healthy parental figures in the first few years of life is the foundation of normal character development. From this early identification, the child moves on to a family identification and then a social identification. All of these identifications are seriously impaired in our disadvantaged adolescent. In fact, these are the sources of his being "disadvantaged."

Identification is largely unconscious. It begins at about the second year and is completed by the fifth or sixth. It is during this crucial period that the child not only establishes his identity as an individual, separate from others, but also his own particular sexual identity as male or female. During this period, the formation of superego or conscience (necessary in establishing "moral" values) also takes place. Identification is established by modeling one's self after, and being influenced by, the attitudes and values of significant parental figures whether natural or substitutive.

With Ruth, there is ample evidence that her identification with parental figures was seriously impaired. When scarcely four years of

age she was placed in a foster home. This placement, which disrupted the identification process with her own parents and required her to reform her identifications relative to her new foster parents, only lasted 11 months. She was replaced in her second foster home just short of five years, a move which demanded a third readjustment in the identification process within a period of one year.

Her original relations with her own parents were characterized by abuse and neglect, their unstable marital relationship and the abandonment of the family by her father who had been denying the paternity of his children. Both parents were hardly suitable models for healthy identification. For a short period before placement, Ruth's mother provided her with another unstable father figure in the form of an common-law relationship which resulted in the birth of the half-sister, Joan. Psychiatric evaluation at age five indicated a serious personality disorder with rigidly controlled feelings and obsessional defenses, psychological mechanisms designed to support a weak identity, both individual and sexual.

John's case is less dramatic than Ruth's and is less informative in terms of historical data in the early years. Knowledge of his parents' character structure and their attitudes toward each other and their children provide significant clues. John had little or no chance for healthy identification with either parent. His father was an ineffectual man whose egocentricity led him to interests outside the home so that there was scarcely any opportunity for healthy identification with a male figure. When he did make his presence felt it was by physical punishment, which increased John's feelings of being rejected and fomented his hostility toward male authority figures. John's mother was even more rejecting. She openly favored his brother and made John the scapegoat for family problems. There was marked inconsistency in establishing rules for everyday living so that superego formation must have been defective.

A second identification process in the preschool years takes place simultaneously with self-identification, i.e., family identification. The identification with family is second in importance only to self-identification. Healthy family identification is necessary in supporting and strengthening self-identification. Of importance here is family unity. How does the family function as a unit? Are the parents in accord? Do they manifest loving and accepting attitudes toward each other? Toward their children? What life style do they favor? Is there an emphasis on intellectual achievement, developing certain talents, materialistic goals, hard work with little pleasure? Is the family religious, irreligious, devoted to long-term gratification or immediate fulfillment? How is responsibility delegated? Is it appropriately apportioned to each parent and to the children or are there inequities inherent in each family member's relationship to the other? What influence does ethnic background have on family identity? Different ethnic styles within the family influence the adolescent's thinking style and behavior patterns (Stein[5]).

Although ethnic attitudes, religious heritage, educational favoritism or bias, interest or disinterest in materialistic gain are important factors in the overall evaluation of any family, stereotypes must be avoided. All disadvantaged families have many features in common, but each family is still individual and variations within their structure can be wide.

Of primary importance in family identity is the background and character structure of the parents in providing a particular model for the child to follow. These intergenerational influences are significant factors in molding the adolescent's self-identity and family identity. The effect of intergenerational relationships is so striking that it has often led to labeling certain personality traits as hereditary rather than environmental.

The influence of interaction between the parental and the grandparental generations in the families of Ruth and John is quite significant.

Ruth's mother was badly treated by her own parents. They, too (as she was in later life)

were declared unfit parents necessitating her placement in an orphanage at an early age. When she returned to her parents at 16, she continued to be subjected to inadequate identifications in the abandonment of her family by her father who had been living in a common-law relationship with her mother. Nothing is known of Ruth's father's family, but the degree of his maladjustment indicates an unstable family background. Ruth's life history closely parallels that of her mother.

John's mother lost her own mother at nine years of age, and had to be placed outside the home because her father was unable to care for her. John's father was orphaned at an early age and was institutionalized until he was 16. Both John's parents suffered serious interruptions in the development of their own identifications.

The effect of these life experiences on both Ruth's and John's family identification provided the distorted models with which both were presented.

In Ruth's case, the family was fragmented at an early age. The problem of parental rejection was severe with family values and relationships weakened and disrupted; in addition, she was required to establish a family identity with two successive foster families before she was five years old. Up to that point, she really did not have a stable family identity. As a result, she brought into her permanent foster home distorted views of how families function, distortions which increased her inability to establish a firm family identity within her foster home and required her to defensively restrict her emotional reactions and control them by obsessional defenses.

John's family, although intact, was nevertheless seriously divided. The values in the home were inconsistent. Responsibility was either shifted from one parent to the other in willy-nilly fashion or was non-existent. Manipulation, coercion, and intimidation were strong features of family functioning. John's father, at one point, actually coached him in extracting money from a vending machine.

In both our adolescents it is clear that their self-identity and their family identity provided little in the formation of what Erikson[10] refers to as "a sense of basic trust." He defines this as "an essential trustfulness of others as well as a fundamental sense of one's own trustworthiness." This basic trust is an essential ingredient of healthy personality development. When it is impaired, it results in a crippled self-identity and an inability to enjoy healthy interpersonal relations.

What about the social identity of our adolescents? This is the third phase in identification development that influences personality structure. Social identity can be defined as the result of the influence of social forces on the maturation process. It is broader in scope than self-identity and family identity. It encompasses economic status, educational background, and cultural influences such as values, beliefs, and attitudes. It results in a set of standards by which the individual judges himself. It is difficult at times to separate social identity from the other two since self-identity and family identity are in a sense determined by social identity. The individual is born into a particular society which has been established and functioning long before his birth. Chronologically, social identity can be said to antedate self-identity and family identity.

Ruth's social heritage from her natural parents is characterized by marginal living, inadequate housing, limited educational background, and the enervating force produced by this type of experience. In her permanent foster home, the living standards were improved but the social discrimination of being a foster child was always present. In addition, there was a lack of intellectual stimulation in the home — the social level of the foster parents, if you will — which accounted in part for Ruth's poor academic performance despite superior intelligence.

In John's case, economic factors were always a serious retarding force. John's father had to struggle to achieve a position of permanence which still required an additional job and the employment of John's mother to sustain the

family economically. Their housing was poor, and the home inadequately maintained. In reviewing the family's social identity, one is struck by a sense of shifting values, a desperate attempt to cope which is never quite sustained and an inability to rise above the morass of retarding social forces. John's sense of social identity is best exemplified by anti-social behavior, which embraces those elements of society whose problems eventually bring them into a confrontation with the law and our judicial system.

The identity crisis is a normal part of adolescent development. It arises when the adolescent is confronted with the demands of an organized society which is highly technological, requiring more and more education, the degree of education being equated with financial security. The adolescent wonders where he will fit into society, what role is he best equipped to play? Can his drive for independence be labeled a success rather than a failure?

The anxiety created by this confrontation with adult society as compared with childhood society is directly proportional to the solidity of the three identities of self, family, and social. Weakness in any of them will determine the degree of anxiety and the extent of the resultant "identity crisis" which is then followed by identity confusion. In an effort to gain time to remobilize his inner resources the adolescent identifies with a subculture of his own peers. This subculture (which in the past has taken different forms in successive generations) has its own set of values, attitudes, and beliefs. These alienate the adult society and provide the adolescent with a temporary identity of his own until he is able to resolve his identity crisis with its accompanying confusion and move on to an adult identity role, commensurate with his abilities. During this period, he reworks and re-evaluates his assets and liabilities attempting to bring into more reasonable persepctive some of the models with which he has identified in earlier years. These models he often finds are either childhood ideals, impractical of achievement in terms of the present, or goals of heroic size out of proportion to his own capabilities. The resolution of the identity crisis, after a certain amount of struggle, is achieved in varying degrees by most adolescents. Some, of course, never resolve the crisis and enter adulthood still confused, floundering and unable to find themselves. Many of these manifest psychopathology ranging from severe character disorders to psychoses.

In applying the concept of the identity crisis to our two adolescents we can see that they are in the midst of it and have not begun to resolve it too successfully. Ruth exemplifies the older adolescent who is graduating from high school with considerable misgivings about her role functioning in society. Her weakened identification has had a great effect on her academic success which has been marginal. It has made serious inroads on her natural talent for art, filling her with doubts concerning her own ability to be successful in this field despite considerable potential. At present she plans to work for a year before attempting enrollment in an art school, a plan which hopefully will resolve her identity confusion.

John, on the other hand, has just entered the period of identity crisis at the age of 14½. He has taken refuge in a delinquent subculture which is adding another handicap to his already limited resources. The weakness of his identification on all levels makes his prognosis poor. His identity with the delinquent subculture provides him with a negative support which may result in a total alienation from constructive society. The road ahead, for him, is fraught with hazard.

Summary

The effect of social forces on personality development is emphasized. The process of identification has been underscored as of primary importance in the maturation of the adolescent. Identification has been divided into three components: (1) self-identity, (2) family identity, and (3) social identity.

The conclusion reached is that the disadvantaged adolescent is "disadvantaged" to the degree that he suffers faulty development in

his identifications, i.e., self, family, and social, and that this faulty identification process is caused by parental, family, and social forces inimical to healthy personality development.

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2175 Hudson Terrace

Psychological Considerations in the care of Patients with Cancer

Probably *all* patients with malignant disease have some awareness of it. At the same time, they will all avoid or deny it in some way, for it represents the ultimate threat to their body integrity and to life itself. They will do this in a manner characteristic of their usual reactions to stress, which emphasizes the need to know all patients in terms of their life experiences. This conclusion is based first on the universal anxiety experienced when they were asked to see a new doctor, followed by the relief on discovering he was a psychiatrist. It was further supported from experiences in office practice where the referring physician, while recognizing the need for psychiatric help, would urge (even order) that there be no reference made to cancer because of the danger of collapse, insanity, or suicide.

We have seen many patients suffer great anxiety and develop a sense of mistrust because they have been told a lie they could not possibly believe or because something offered casually one week must be abandoned the next.

The patients think of their lives in potentially normal terms and want to speak of the realities of daily life. They must be permitted to do so, while we at the same time must recognize that these daily concerns are being used by them to gauge the course of their disease.

For the patients, the greatest threat seemed to be not so much that of death, but rather of pain, helplessness, rejection, and progressive isolation. Studies of chronically ill people (especially cancer patients who think in terms of disintegration) have shown how intense the fear of abandonment is. It is feared more than death itself. It is usual that we are frightened of things about which we may have some experience or memory. Death is beyond our conscious and unconscious experience (at least subjectively) and cannot be conceptualized; for this reason death is most often equated with abandonment. In the chronically ill person this fear of being unloved and isolated is everywhere.

S. L. Feder: *Ann. N.Y. Acad. Sci.,* 125:1020 Jan. 21, 1966.

Although tympanoplasty is often disappointing in terms of improved hearing, it usually affords excellent control of infection.

Tympanoplasty*

Results at Twelve and Twenty-four Months

Julio T. Noguera, M.D. and F. Robert Haase, M.D./Neptune

Since the pioneering work of Wüllstein[1] and Zollner[2], and subsequent work of Sheehy[3], Guilford[4] and Goodhill[5] in tympanoplasty, numerous technics have been described. This multiplicity is usually a sign of unsatisfying results.

Actually, the results of controlling infection have been satisfactory; but the *hearing* results have been unpredictable and, on the average, rather poor. We use the phrase "on the average" with premeditation, because this is the way we use it here to report our hearing results. It is reached in individual patients by adding the hearing by air at frequencies 500, 1000, and 2000 and dividing by three. This is the preoperative base line. Postoperatively, the average is determined at twelve and twenty-four months. On each occasion there may be a gain or loss of hearing. All gains are added, from which is subtracted the sum of all losses and the difference is divided by the total number of patients. This provides us with an average reading in decibels of what we have accomplished. Results are reported this way because we feel that *every* patient taken to the operating room should be included in the series. Reporting hearing results has become a hodge podge of figures because each author selects his cases to be reported in a different way.

Our technics include conventional tympanoplasties (according to the Wüllstein classification) and a small group of reconstructions with a silastic prosthesis designed by Haase, and later modified by both authors. The conventional methods used were:

Type I. The ossicular chain is intact. Any other pathology present does not require removal of any ossicles. This includes cholesteatoma that can be removed from the middle ear or mastoid without destroying the ossicular chain, or tympanosclerosis when good mobility of the ossicles could be obtained at the time of surgery.

Type II. The ossicular chain is reconstructed by repositioning the incus or malleus over an intact stapes. Or the incus is placed between a mobile footplate without crurae and the handle of the malleus, or the short process of the incus is placed on the mobile footplate and the body in direct contact with the tympanic membrane.

Type III. This is a simple tympano-stapediopexy, whether the malleus was present or not, and whether the patient's own tympanic membrane or a reconstructed one was used.

Type IV. This is the so-called *cavum minor* operation. Only a small group of ten is presented because in these cases we have substituted the ossicular chain with a silastic prosthesis.

The prosthesis† consists of a diaphragm measuring nine millimeters in diameter, placed on a ring of the same material that is three quarters of a circle. The ring is one millimeter wide and two millimeters deep. In the section where the ring is absent, a silastic piston is fused to the diaphragm and measures one millimeter in diameter and six millimeters in length. At the tip of the piston a small tuft of Dacron is fused into it.

In 1964, seeking a way to simplify reconstruction of Type IV candidates and old radical mastoidectomies, Haase designed the prosthesis. It was placed, with the ring and diaphragm, in the middle ear after the pathology was removed, with the piston on the denuded

* Read before the Section on Otolaryngology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969.

† Made by Dow Chemical Corporation of Midland, Michigan.

but mobile footplate. The one quarter defect in the ring was made so that it could fit under the facial ridge. The new tympanic membrane (made of temporal fascia) was then placed over the diaphragm. The *initial* hearing improvement was encouraging, but within six months it would diminish. We felt that the close apposition of the tympanic membrane to the diaphragm was lost, and we wove several pieces of wire (surgical stainless steel number four) through the diaphragm converging on the area of attachment of the piston. This modification would increase transmission of vibrations to the piston and give the new tympanic membrane a place to attach to the prosthesis. Again, we found that hearing dropped in about nine months. We felt that the tip of the piston was detaching itself from the footplate, as patients would lose the hearing sometimes after a sneeze.

A tuft of Dacron was fused to the tip of the piston to stimulate fibrosis at the footplate after removing the mucosa. While we did this, we decided to incorporate Dacron mesh to the diaphragm to stimulate fibrosis and attachment to the tympanic membrane. The hearing results were no better. In about six months, for the first time in our experience with the prosthesis, they began to extrude. The Dacron in the diaphragm causes atrophy in the tympanic membrane with eventual perforation and infection. This modification was quickly discontinued and we are back to weaving one or two wires, but keeping the Dacron at the tip of the piston. Results of the prosthesis, as it is used today, are not reported, as we have insufficient follow-up time.

The prosthesis also prevents adhesions between the tympanic membrane and promontory in total perforations. Instead of using a silastic sheet that may slide out of position, a pie-shaped piece of the prosthesis is removed, including the piston, so that the defect will fit in the area of the stapes and placed in the middle ear prior to using the fascial graft. Also, it holds in position a repositioned incus on top of the stapes when there is no malleus. A small pie-shape section including the piston is removed so that the head of the stapes protrudes through the defect and the body of the incus is placed on top of the diaphragm in contact with the stapes. By the same fashion, it can hold up an incus whose short process is in contact with the footplate and the new tympanic membrane is placed on the body of the incus for a columellar effect.

The hearing results, obtained as previously described, follow. All operated cases with sufficient follow-up are included (see Figure 1). In Figure 2 it can be seen that the overall gain is poor. Type III gave the best result. The twelve months improvement dropped in all types at twenty-four months. Figure 3 shows the range of difference between the gainers

FIGURE 1
TYMPANOPLASTIES
April 1959—April 1969

Total Number	420
Cases Used In Study	159

Reasons For Elimination
(1) Lost to follow up (approx. 50 per cent)
(2) Insufficient follow up (after April 1967)
(3) Cases with silastic prosthesis

FIGURE 2
TYMPANOPLASTIES (159)
Average Closure Of Air Bone Gap In DB

Months Postop	Type I (58)	Type II (63)	Type III (28)	Type IV (10)
12	6 DB	6 DB	8 DB	1 DB
24	2 DB	2 DB	5 DB	1 DB

FIGURE 3
Range of Differences In Widening (W) or Narrowing (N) Of Air Bone Gap In Decibels

Months Postop	Type I		Type II		Type III		Type IV	
	W	N	W	N	W	N	W	N
12	11	33	12	25	10	14	16	13
24	11	30	29	36	20	32	21	28

FIGURE 4
SILASTIC PROSTHESIS
April 1964—April 1967

Months Postop	12	24
No. Patients	30	14
DB Average Closure	3.3	1
Range Differences—Gap Widened	23	31
In Decibels —Gap Narrowed	25	22

FIGURE 5
Comparison Of Silastic Prosthesis With Tympanoplasty Type IV Closure Of A-B Gap In DB

Months Postop	Prosthesis	Type IV
12	3.3 DB	1 DB
24	1 DB	1 DB

and the losers. In Type I the greatest loss that did not get worse at twenty-four months, was eleven decibels. The greatest loss in all other types at twelve months became worse in twenty-four months. On the other hand, the greatest gainers tended to get better at twenty-four months as compared to twelve months. Some of them are quite dramatic as in Type II where the greatest gainers had thirty-six decibels of improvement and in Type IV, twenty-eight decibels. In Figure 4, the results of the silastic prosthesis are presented. The average gain at twelve months was 3.3 decibels, and at twenty-four months, one decibel. The greatest losers decreased by 31 decibels at twenty-four months, and the greatest gainers improved by 22 decibels at twenty-four months. In Figure 5, a comparison is made of Type IV and the silastic prosthesis results. At twenty-four months the gain is the same.

Conclusion

Tympanoplasty today produces, in the long run, insignificant average hearing improvement, although infection control has been good. The silastic prosthesis, as used at present, is not extruded even in the presence of an acute infection and helps to preserve a middle ear cavity. Other modifications may make it a more efficient sound transmitter to the footplate of the stapes. We propose that long term reporting should include all operated cases to get a true picture of our accomplishments, lest we be deluded into a false sense of success and inaction.

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Our special thanks go to William H. Petersen M.A. and Marcelyn Lederer M.A. for their invaluable assistance in preparing the statistical data.

2100 Corlies Avenue

Healthful School Living

As a doctor, you are concerned about a child's physical health. But this is bound up with social and emotional health, too. And since a child spends so much of his waking time in school, the emotional climate of the school has a major impact on his total development. As physicians, we have not fully sensitized ourselves to this. The National Education Association has joined with the AMA in developing a book, *Healthful School Environment.* This is part of the trilogy serving as reference for teachers, school administrators, members of boards of education, and others responsible for school programs. The two counterparts are *Health Education* and *School Health Services.*

The new book emphasizes that schooling is a "total experience," not just an "intellectual" exercise. It reminds us that "healthful school living" means living within a school where all environmental conditions, every social relationship, and every curriculum experience is carried on with due attention to health. Among the topics are the emotional setting of the classroom, school food services, lighting and acoustics, air conditioning, heat and ventilation, water supply, plumbing and waste disposal.

Copies are available from the AMA (535 North Dearborn Street, Chicago 60610), $6 in hardcover and $4 in paperback.

So far as is known, this is the first operation of this type to have been performed in New Jersey.

Replacement Of The Thoraco-Abdominal Aorta*

Victor Parsonnet, M.D., Ramon Sy, M.D., Joseph Alpert, M.D., and Donald K. Brief, M.D./Newark

Aneurysmal dilatation of the upper abdominal aorta is a challenging lesion to treat because the major abdominal visceral arteries arise from this segment of the aorta. Such aneurysms frequently extend proximally through the diaphragm to involve the descending thoracic aorta, and distally to the bifurcation of the aorta or beyond to the common iliac arteries. Extensive surgery in two body cavities is therefore required for successful treatment. There is danger of producing irreversible ischemia of one or more of the visceral organs during the resection and graft replacement. A series of 46 such operations was reported by DeBakey[1,2] and co-workers; eleven patients died within one month, and 27 were alive and well up to 10 years.

A 63 year old man had been admitted to another hospital for treatment of sigmoid diverticulitis. There a routine chest x-ray demonstrated a thoracic aneurysm. The patient was transferred to the Newark Beth Israel Medical Center for further evaluation. There were no symptoms referable to the aneurysm. Except for mild constipation, the system review was not remarkable.

He was a well developed and nourished man with a blood pressure of 160/100. Heart sounds and rhythm were normal and there were no murmurs. The abdomen was soft and flat. No pulsating masses were palpable. The extremities and peripheral pulses were normal.

Laboratory studies were entirely within normal limits, including total proteins, hemogram, serum chemistries and electrolytes. Electrocardiogram showed normal sinus rhythm, left axis deviation, and first degree A-V block. Pulmonary function studies were normal. (Figure I)

On March 12, 1968 the thoracoabdominal aorta was resected and replaced with a Dacron prosthesis from the mid-thoracic aorta to the bifurcation. The celiac axis, superior mesenteric, and both renal arteries were anastomosed separately to the graft. He tolerated the procedure well, requiring 3,000 cubic centimeters of blood during the operation. Central venous pressure and blood gases were monitored frequently in the post-operative period. Respiratory assist was used for 24 hours, and thereafter intermittent positive pressure breathing was used. Vital signs remained stable throughout, and there was an adequate urinary out-

Figure I



Pre-operative retrograde aortogram of the thoraco-abdominal aorta. Dotted lines indicate extent of aneurysm. Note fusiform dilatation of the aorta above the aneurysm, and the buckling and tortuosity just above the take-off of the aneurysm.

* From the Department of Surgery, and the Division of Vascular Surgery of the Newark Beth Israel Medical Center. Dr. Sy is a resident in Vascular Sugery.

put. Transient increase of the blood urea nitrogen to 49 milligrams per cent reverted toward normal before discharge. There was some limitation of respiratory excursion because of the large thoraco-abdominal incision, but frequent chest x-ray determination showed satisfactory expansion of both lungs and the thoracotomy tube was removed on the 4th post-operative day. An intestinal fungus infection on the 7th post-operative day was treated successfully with Mycostatin.®

Figure 2

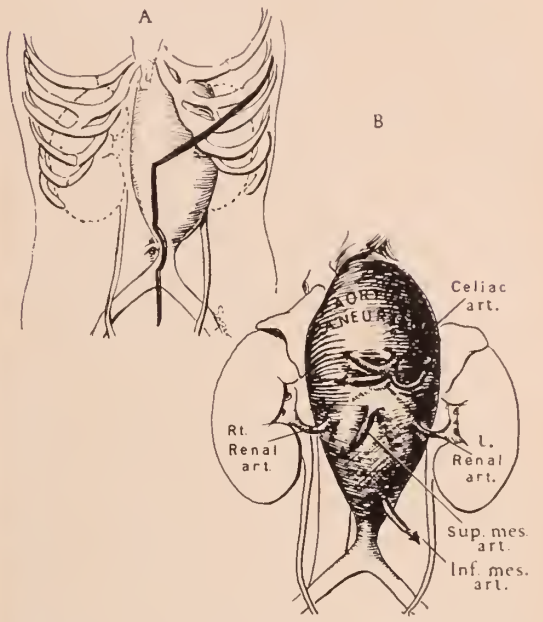


Post-operative retrograde aortogram. The catheter tip is at the take-off of the graft. The blind end of the upper aorta is barely visible. The lettered arrows indicate the visceral vessels. (A-celiac artery; B-superior mesenteric artery; C-splenic artery; D-right renal artery; E-left renal artery.)

On March 28, 1968 a retrograde aortogram showed excellent function of the prosthesis, with normal opacification of the visceral arteries. (Figure II) The patient was asymptomatic and well nine months after surgery.

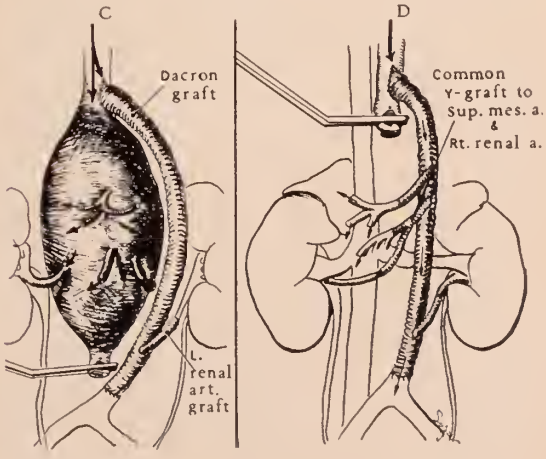
The major considerations in resection and graft replacement of an aneurysm of the thoracoabdominal aorta are to obtain adequate exposure of the lesion and the branch arteries, and to limit the ischemic time of the abdominal viscera during the period of cross clamping of the aorta. This period should be as short as possible, probably less than one hour.

Figure 3 — A and B



Insert A demonstrates position of the incision, and B the approximate extent of the aneurysm as found on exploration.

Figure 3 — C and D



Insert C reveals the first step of the anastomosis, with end-to-side connection of the graft to the aorta above the aneurysm, end-to-end connection below the aneurysm, and re-anastomosis of the left renal artery. Note the flow continues to the other visceral vessels. Insert D illustrates method of completion of the resection with anastomosis of the other limbs to the remaining visceral arteries. (see text for details).

The patient was placed in the supine position (Figure III) with the left side of the body elevated and the left arm elevated. The thoracic and abdominal cavities were entered through a thoracoabdominal incision, and the diaphragm divided to the aorta. A thorough exploration was made to determine the extent of the lesion and associated pathology to assure that resection was feasible. The abdominal viscera, including the left colon, spleen and pancreas were retracted to the right exposing the aorta and the left kidney. Proximal and distal control tapes were passed about the aorta. A Dacron® tube of suitable size was then anastomosed end-to-side to the descending aorta by partial exclusion technic. The prosthetic bypass from the thoracic to the abdominal aorta maintained circulation to the legs during the resection of the lesion and this graft subsequently became the permanent replacement of the excised aorta. Following completion of the proximal anastomosis the graft was occluded at its origin and the lower limb of the graft was anastomosed to the end of the aorta below the renal arteries. The graft was then opened allowing blood to flow to the lower extremities.

Knitted Dacron® tubes 8 millimeters in diameter were attached to the bypass graft by end-to-side anastomosis using a partly occluding clamp to the graft. The left renal artery was anastomosed first. Following completion of this anastomoses, the descending aorta was clamped below the origin of the graft and the aneurysm was partly resected. A previously attached Y-shaped limb was rapidly anastomosed end-to-end to the right renal and superior mesenteric arteries. The celiac artery was similarly attached to the graft. During the procedure, heparinized saline was injected into the major arteries. The total ischemic time did not exceed 20 minutes for any of the major arteries. Following restoration of circulation the remainder of the aortic aneurysm was excised. The blind end of the thoracic aorta below the clamp was oversewn with Dacron® sutures. The abdominal and chest incisions were then closed, and a thoracotomy tube was placed in the left chest.

Summary

An operation that minimizes ischemia to the viscera has made possible the successful resection and replacement of a large aneurysm of the thoracoabdominal aorta. Long-term follow-up indicates that visceral function has been preserved and that the patient remains well 9 months following the operation.

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Acknowledgment: The authors wish to thank Mr. Thomas Coullahan and Mrs. R. T. Soper for the photographs and illustrations.

201 Lyons Avenue

Recruitment of Black Medical Students

The AMA and constituent and component medical societies are making an effort to attract more black students to the study of medicine. Joining in this program are the National Medical Association and individual medical schools. A new motion picture has just been released by the International Afro-American Museum, in cooperation with the Detroit Medical Society. Entitled "You Can Be a Doctor," it is in color, 15-minutes, and available from the Museum at 1549 West Grand Boulevard, Detroit 48208.

In spite of many wondrous new antibiotics, staphylococci pneumonia still has a high mortality.

Staphylococcal Pneumonia*

A Review of 30 Cases

Samuel Cohen, M.D. and Alfredo D. Recano, Jr., M.D./Jersey City

This is a review of thirty patients admitted to the Pollak Hospital for Chest Diseases in the ten year period beginning in January 1958. This study is restricted to patients: (1) with "primary" staphylococcal pneumonia; (2) in whom hemolytic *staphylococcus aureus* coagulase-positive organisms were isolated from the sputum and/or pleural fluid; and (3) who had abnormal chest x-ray findings. This also emphasizes results of long-term follow-up examination with especial reference to serial residual roentgen findings affecting the parenchyma, particularly the so-called pneumatocoele.

Clinical Data

Epidemiologic Information: Twenty of the thirty patients were admitted during the three year period 1958 to 1961. The final inventory date for follow-up studies was December, 1968. Table I summarizes the incidence according to age, sex, and race.

Predisposing Factors: Upper respiratory tract infection or viral respiratory disease (and especially influenza) may increase susceptibility to staphylococcal pneumonia.[1,2,3] Debilitated patients, and children with a congenital defect seem to be more predisposed. In our series, 63 per cent of the patients had significant concurrent associated clinical conditions. These are itemized in Table 2.

There are other factors such as localized cutaneous or osseous staphylococci foci, for example, which may result in a bacteremia with secondary pulmonary implantation, but these were excluded from this study.

Onset was acute in fourteen patients (47 per cent) and insidious in sixteen (53 per cent). The specific features of the symptom complex are visualized in Table 3.

Findings on Admission

Laboratory: Anemia was common. The white blood cell count ranged from 5,000 to 34,000. Others have observed leukopenia especially in debilitated adult patients. Positive blood cultures were obtained in three patients (10 per cent) although samplings were not made in all. In only one case was there subsequent evidence of distant lesions. All recovered from the acute process.

X-Ray: While bacteriologic proof definitely identifies the disease, certain x-ray findings may increase the likelihood of staphylococcal pneumonia.[1,4,5,6]

While an overlapping of criteria is inevitable, the following were the predominant thoracic roentgen findings on admission: (a) Slight abnormality interpreted as pleural reaction — two cases; (b) pneumothorax or hydropneumothorax with or without associated pulmonary infiltration — six cases or 20 per cent; (c) bronchopneumonic infiltration of varying extent and confluence frequently associated with single or multiple areas of "hi-lite" (sometimes with fluid levels) and some also had a pleurisy — twenty-two cases or 73 per cent. Of these, fourteen were unilateral and eight bilateral in distribution.

* From the B. S. Pollak Hospital for Chest Diseases in Jersey City. Dr. Recano is Chief Resident there and Dr. Cohen is Medical Director.

Prognosis and Mortality

Before the availability of antibiotic therapy, staphylococcic pneumonia had a high mortality. This was significantly reduced[4] with the introduction of penicillin in 1941. The prognosis has also improved in recent years due to: (a) the changing ecology of staphylococcal disease; (b) vaccination against influenza; (c) the availability of newer antibiotics — especially penicillinase resistant penicillins.

Four patients (13 per cent) in our group died during the course of the staphylococcal pneumonia in spite of antibiotic therapy. They were between the fifth and sixth decades of life, debilitated with serious associated diseases; two with advanced active pulmonary tuberculosis, one with bronchogenic carcinoma and one with chronic obstructive pulmonary disease and associated chronic cor pulmonale.

Treatment

In addition to the traditional regimen in the general management of acute bronchopulmonary infections, treatment consists of the early and adequate use of proper antibiotics. Soon after the introduction of penicillin, most strains of staphylococci were susceptible to it. Later it became apparent that an increasing number of strains produced penicillinase and that organisms were resistant in a variable degree to the action of penicillin G *in vitro* and *in vivo*. The development of semisynthetic penicillinase-resistant penicillins has greatly improved antimicrobial therapy of this infection. Methicillin[7] is virtually totally resistant to staphylococcal penicillinase[8] and methicillin exerts a bacteriocidal action in the blood to practically all present strains of staphylococcal infections (regardless of whether they produce penicillinase) in the dosage of one gram intramuscularly every four hours. Methicillin, then, at this time, is the drug of choice. It has the disadvantage that it must be given parenterally and can cause some side reactions but is generally well tolerated. Methicillin should preferrably not be used in patients sensitive to penicillin (although there is not perfect cross sensitivity between the two). The second choice of drugs is cephalothin, also given by injection. The usual adult daily dose may be the same as for methicillin or higher. (Loridine intramuscularly may be less painful.) Vancomycin is probably as effective as methicillin in treating severe infections but has the disadvantage of intravenous administration (one gram every twelve hours, 200 to 300 cc of 5 per cent dextrose and water) resulting in frequent local phlebitis, drug rash, eighth nerve involvement and aggravation of pre-existing renal dysfunction.

Other semi-synthetic penicillins, such as oxacillin, cloacillin nafcillin, are also effective and can be given orally but variability in gastrointestinal absorption makes this route less desirable in the management of severe staphylococcal pneumonia; furthermore, oxacillin, for example, is bound to serum proteins, is rapidly inactivated by serum *in vitro* and for this reason,[9] adequate blood levels are not well maintained beyond 2 to 4 hours.

Tetracycline, erythromycin, chloramphenicol and lincomycin are effective against a variable number of strains of staphylococci with the last two mentioned drugs probably being more effective.[10]

The antibiotics used in our patients were methicillin, chloramphenicol, albamycin, novobiocin, vancomycin, kantrex, tetra-acetyl oleandomycin (TAO), cathomycin, declomycin — usually in combination.

Selection of the proper antibiotic is based upon sensitivity studies of the staphylococcal strain and the severity of the infection. The pragmatic clinical approach often necessitates the initiation of treatment before the determination of the responsible organism and strain and sensitivity of antibiotics. For this reason, it is best to choose initially the most effective antibiotic. To recapitulate, *as of today*, first priority is given to methicillin and if the patient has an allergy to penicillin, then the use of cephalothin. The need for combination drug therapy will vary with the bacterial

sensitivity studies, the severity of the infection and the clinical response.

Attention is focused on the complication of empyema. Eight patients (27 per cent) developed this. In two of them, the fluid was small in amount and thoracentesis alone with continuation of antibiotics was adequate. Intercostal tube drainage was done in four. This procedure followed by decortication was performed in the remaining two because of the chronicity of the empyema. There were no surgical complications and the pleural space was obliterated in all. Successful therapy depends on early diagnosis, use of the proper antibiotic, adequate drainage, and obliteration of the space.

Post-hospital Discharge Status

1. *Died.* Of the 26 patients who left the hospital after the first admission, 7 (or 27 per cent) were re-admitted and died within a four year period. Five died of congestive heart failure, one of aspiration pneumonia and one of uremia with associated re-activated pulmonary tuberculosis. Two of the other six also had tuberculosis; in one it was inactive and in the other there was temporary bacillary exacerbation controlled by chemotherapy. One patient who signed a release with an intercostal tube *in situ* for his empyema was re-admitted three weeks later and died in cardiac failure. In the remaining three patients, complete clearing of the staphylococcal pneumonia was present in one on discharge, marked resolution in another and the third had a residual pneumatocoele three months later.

2. *Living.* Six of the 26 patients (23 per cent) were alive up to nine years (the longest follow-up) after the first hospital discharge. Three had complete clearing at that time. In one patient, pneumatocoeles persisted for at least 21 months (then lost to observation) (Case 1); in the other two (who had underlying associated chronic pulmonary tuberculosis), the residual large areas of radiolucency probably represented bullae noted up to 29 months and 9 years after discharge.

Of the group without follow-up, four showed no residual infiltration, four had some remaining parenchymal process (none had pneumatocoeles) and five residual pleural thickening at the time of discharge. These individuals could not be located. It might be assumed that no late complications of the original pneumonia developed.

Case

A female, age 22, was admitted by transfer from a local hospital where tuberculosis was diagnosed on the basis of x-ray findings (Fig. 1). Onset — first week in February with cough, sputum, fever, chest pain and 5 pound weight loss, sputum blood streaked twice. On admission, she was febrile, had moderate leucocytosis. The tuberculin test was positive. Her sputum was negative for acid fast bacilli but positive for staphylococcus aureus, coagulase-positive. She was placed on novobiocin with marked clinical and x-ray improvement. She was discharged six weeks after admission to continue chemotherapy for four to six more weeks.

Note the evolutionary fate of confluent infiltration and pneumatocoeles (Fig. 1 to 4) which persisted on last available film. She was lost to follow-up two years later. An x-ray film taken at time of a pre-employment examination before hospitalzation was negative — ruling out pre-existing cystic disease.

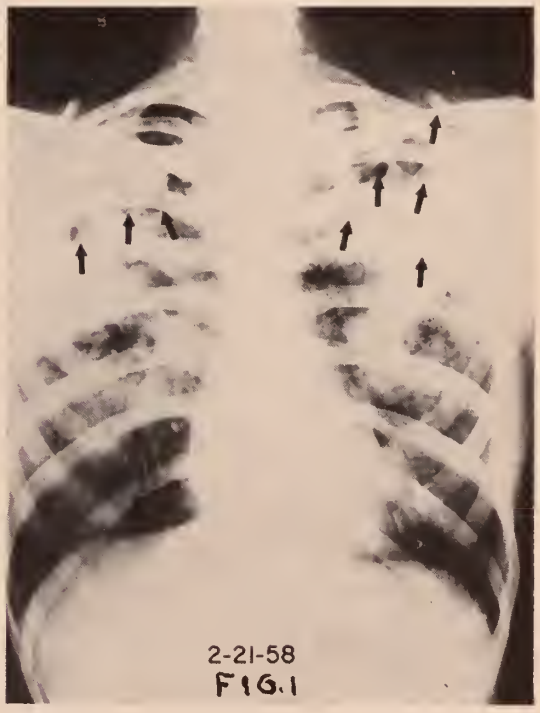


Figure 1

Radiographic Features

While bacteriologic proof is conclusive, findings on the chest roentgenogram in many cases had certain distinctive features. A rapid-

ly changing x-ray appearance in the presence of an unchanging clinical course may confuse the clinician. To appreciate the rapidity of the roentgen changes during the acute proc-

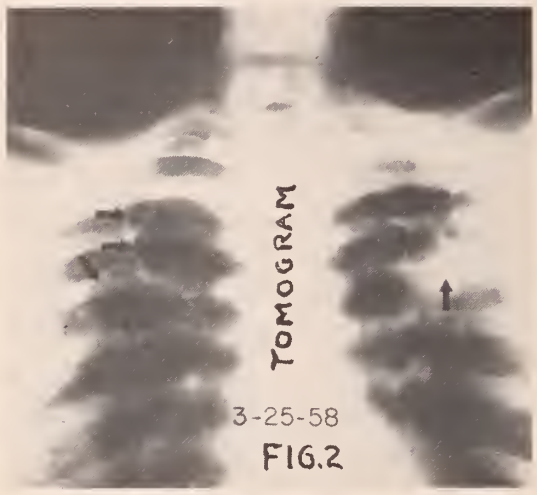


Figure 2

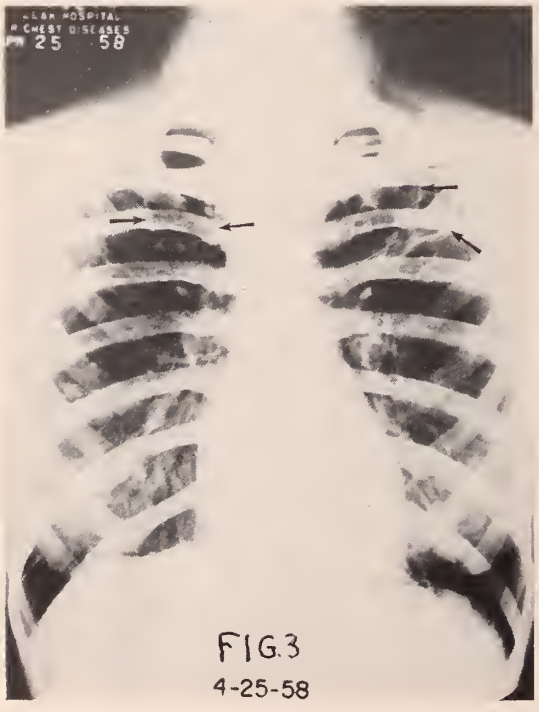


Figure 3

ess, frequent serial films should be made. An area of patchy or homogenous pneumonic infiltration may become replaced to varying degree by single or multiple cyst-like hyperventilated areas called pneumatocoeles which are non-epithelialized positive pressure "cavities" resulting from infection with a check valve bronchial mechanism. While seen characteristically in staphylococcal pneumonia, they do occur in suppurative or necrotizing pneumonias of other bacterial etiology. The infectious process produces an endo, meso, and peribronchitis with formation of a peribronchial abscess which perforates

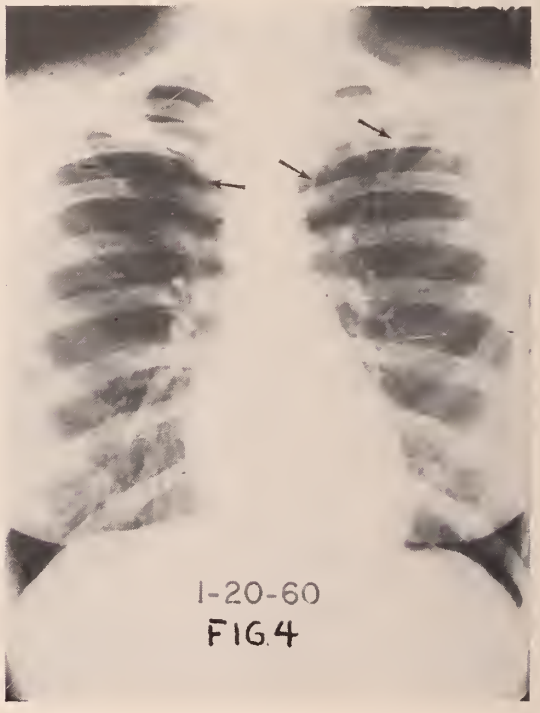


Figure 4

into a bronchus resulting in evacuation of its contents (partial or complete) producing an air or air and fluid containing defect in the interstitial tissue. The check valve mechanism caused by inflammation and edema is postulated to explain the marked fluctuations in size which may sometimes be seen. Shifting fluid levels due to purulent exudate within the "cavity" may appear and disappear on x-ray during the course of the lesion. The granulation tissue lining of the "cavity" becomes progressively thinner as the "cavity" enlarges under tension and with further resolution of the inflammatory process there appears the classical thin walled pneumatocyst. These cysts appear related (in part) to

delayed or inadequate chemotherapy and an incidence as high as 61 per cent has been reported.[4] Usually, they disappear spontaneously within a matter of several weeks as the infection subsides but very occasionally there is persistence for a considerable period of time. Tomography clarifies delineation (Case 1). Surgical treatment is not necessary for a true uncomplicated pneumatocoele.

Differential problems include the following: (1) pneumatocysts may closely simulate a pneumothorax or hydropneumothorax but actual rupture into the pleural space may also occur with these resultant complications and surgical treatment is then indicated — this diagnostic problem arises more frequently in infants than in adults; (2) a congenital cyst usually does not fluctuate in size. Infection is far more frequent as the child gets older — and incidentally the cyst is lined by bronchial epithelium, usually columnar and often ciliated; (3) pneumatocoele may closely resemble a bulla which is a non-epithelialized air space lined by fibrous tissue and produced by rupture and coalescence of alveoli. Sometimes a check valve mechanism may lead to accumulation of secretions within the bulla and simulate a lung abscess or an encapsulated hydropneumothorax — a bulla or bullae may occur in: (a) an otherwise healthy lung; (b) associated with chronic obstructive emphysema or (c) with fibrosis secondary to infection and/or noxious inhalants (such as tuberculosis and silicosis and (d) in the "vanishing lung syndrome." (Bullae do not disappear but tend to increase in size, usually slowly. Surgical treatment may be the procedure of choice in selected cases); (4) in adults particularly, an initial erroneous roentgen diagnosis may be made of tuberculosis (as occurred in several of our cases) especially when the infiltration and pneumatocoeles are bilateral (Case 1). Frequent serial roentgenograms and sputum examinations[4] should quickly clarify the problem. If the staphylococcal pneumonia is engrafted on a so-called "virgin pulmonary parenchyma," resolution will proceed at a faster rate (other things being equal) than if it is superimposed on a previously damaged lung due to emphysema, fibrosis, bronchiectasis, tuberculosis, and the like. The prophylactic use of isoniazide is warranted in the presence of the latter. Reactivation of an old tuberculous lesion can occur and the concurrent presence of the two different etiologic processes may lead to difficulty in evaluation of some shadows, particularly areas of increased radiolucency. This problem was noted in several of our cases. Serial sputum and roentgen studies should be done.

TABLE 1

Age on adm.	*No. of cases*	*Per cent*
Below 13 years	4	13
Between		
13–15 years	8	28
46–65 years	14	46
Over 65 years	4	13
Sex		
Male	21	70
Female	9	30
Race		
White	28	93
Non-white	2	7

TABLE 2

Associated Clinical Conditions	*No. of Cases*
Pulmonary tuberculosis, active	4
Pulmonary tuberculosis, inactive	3
Congestive heart failure	3
Bronchogenic carcinoma	1
Pulmonary emphysema and fibrosis	1
Chronic alcoholism	1
Diabetes mellitus	1
Pyelonephritis	1
Rheumatoid arthritis	1
Bronchial asthma	1
Patent ductus arteriosus	1
Rheumatic heart disease	1
Total	19

TABLE 3

Symptoms and Signs on Admission	*No. of Cases*	*Per cent*
Acute onset	14	47
Insidious	16	53
Pulmonary Symptoms		
Cough with or without sputum	30	100
Dyspnea	11	37
Chest pain	9	30
Hemoptysis (frank or streaked)	6	20
Wheezing	6	20
Cyanosis	2	7
Abnormal physical signs	27	90

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Carcinoma of the Breast, a Decade of New Results with Old Concepts

This tumor stands unique as the commonest malignant tumor of middle-aged women, and the leading cause of death in white women in the United States, thirty-nine to fifty-four years of age. No single manifestation of cardio-vascular or renal disease, no single infection and no complication of pregnancy or parturition takes such a toll of the mother in her prime.

If one acknowledges that the passage of time is required for a tumor to progress from its initial focus to lymph-node metastasis, the corollary must also be accepted that early diagnosis presents the patient with the greatest likelihood of survival: a localized tumor without spread.

The genetic soil in which this disease arises has been explored extensively. Both Woolf and Anderson, *et al.* found that the hereditary tendency is for breast cancers specifically, and not merely for malignant tumors in general.

The same concern applies to the remaining breast after mastectomy for cancer: in approximately 10 per cent of patients surviving for more than three years the lesion will develop in the opposite breast.

Failure to nurse for longer than three months is associated with a higher risk of breast cancer.

The disease is significantly less frequent in married women who have borne children than in single nulliparous women. A disproportionately large number of these patients (20 per cent) were single women, and a full 34 per cent of them were nulliparous.

In a patient who has had a carcinoma of the breast removed, and in whom further pregnancy is to be avoided for fear of exacerbation of dormant metastases, the oral contraceptive pills are positively contraindicated. Many contain progestins, and others estrogens, both substances that will stimulate the growth of dormant breast metastases. A recent study has shown marked stimulation of advanced breast cancer — evidenced by acute hypercalcemia — after the administration of a modified progestational agent, medroxyprogesterone acetate (Provera).

Previous oophorectomy appears to reduce the incidence of breast cancer. If this disease develops in a patient who has undergone prior oophorectomy, she then has a significantly worse prognosis.

F. D. Moore, S. I Woodrow, M. A. Aliapoulios, R. E. Wilson: *New Engl. J. Med.*, 277:293 August 10, 1967.

Radiation itself may produce carcinoma-like symptoms, suggesting a recurrent malignancy. Look before you reoperate!

Simulated Recurrent Cancer Of The Cervix Following Irradiation

Report of a Case

Arpad G. Gerard, M.D. and Alexander Strelinger, M.D./Woodbridge

Sequelae from irradiation for carcinoma of the cervix may simulate recurrent cancer. Differential diagnosis between cancer recurrence and radiation granuloma may be difficult and fraught with error. Either condition (recurrent cancer or radiation granuloma) may be accompanied by intense pain. This may lead to liberal administration of narcotics and consequent addiction. Such were the circumstances in a patient who, by a fortuitous succession of events, was fully rehabilitated.

A 43-year-old married woman, gravida 1, para 1, was first seen by one of us in May, 1951. Chief complaint was continuous incapacitating abdominal pain of over a year's duration, associated with malnutrition and weakness.

She had felt well until August, 1948, when she was admitted to Duke Hospital in Durham, North Carolina, with the diagnosis of carcinoma of the cervix, Stage I (League of Nations classification). In July, 1949, radium was implanted intrauterinely, intracervically, and intravaginally at the Maryland General Hospital in Baltimore. Total dosage was 4500 mgm hours. Diagnosis at that time was "squamous-cell carcinoma of the cervix with parametrial extension, clinical Stage IV." Subsequently, a rectovaginal fistula developed. Six months later, in the Maryland General Hospital, a sigmoidostomy was done, following which the patient's condition deteriorated markedly. She developed continuous severe abdominal pain, which necessitated daily administration of 10 to 15 injections of narcotics, with only temporary relief.

The patient was fully aware of the diagnosis and prognosis of her condition. She came to us for further treatment with a letter from her family physician to the effect that inoperable carcinoma extended to the sigmoid and rectum; that the sigmoidostomy was done to relieve rectal obstruction; that the case was terminal, and therefore narcotics should be given freely for pain relief.

On May 14, 1951, our examination revealed an obviously ill woman with evidence of malnutrition and loss of weight. She was apprehensive and in distress. Positive physical findings were limited to the abdomen and pelvis. She had a functioning sigmoidostomy. There was marked tenderness in the lower abdomen. A mass, the size of a melon, without definite outline, could be palpated in the lower abdomen. Motion of the cervix produced pain in the lower abdomen, but because of severe discomfort, adequate palpation was not possible. Vaginal inspection disclosed ulceration of the upper half of the vagina below the abdominal mass, extending onto the posterior vaginal wall and causing a large rectovaginal fistula. A large volume of pus exuded continuously *per vaginam*, necessitating continuous application of pads.

In the ensuing two years, she continued the frequent use of opiates. She was unable to work, and spent much of her time in bed, though her basic condition did not deteriorate further.

On July 20, 1953, the patient was hospitalized in the St. Elizabeth Hospital, Elizabeth, New Jersey to be evaluated for pelvic exenteration. In addition to the findings on cystoscopy, sloughing tissue was seen in the right upper section of the urinary bladder. This was assumed to be carcinoma extension; no biopsy was taken. Pelvic exenteration was not done because she could not afford to obtain enough of her type of blood, Rh negative. She continued to take narcotics with increasing frequency after her discharge from the hospital.

On March 6, 1955, she was rehospitalized. Her status appeared fairly good for having had extensive cancer for seven or more years. No slough was seen in the bladder. Doubt arose whether the sloughing tissue seen in 1953, actually had been carcinoma. The vaginal ulcerated fornix and edges of the rectovaginal fistula were biopsied. No malignancy was found. Therefore it was decided to attempt excision of all diseased tissue with possible preservation of the entire urinary tract. The patient had no antibodies for Rh positive blood and had a negative Coombs test. Two weeks later a combined abdominovaginal perineal procedure was carried out, with simultaneous transfusion with adequate amounts of the Rh positive (but otherwise group compatible and cross-matched) blood. On operation, it

was found that the abdominal mass incorporated the uterus, both tubes, both ovaries, a section of the sigmoid, a section of the rectum, and the upper half of the vagina (Figure 1). These were embedded into a fibrous mass containing many small abscesses. The sigmoid cephalad was transected to the sigmoidostomy; the sigmoidostomy freed from the abdominal wall; the mass freed from the ureters and from the bladder; and then the mass was separated posteriorly from the sacrum and posteriorly to the bladder. Finally, the rectum was transected below the rectovaginal fistula and vagina at its midpoint. All diseased tissue was removed in one block. The splenic flexure was mobilized and enough length of bowel obtained to anastomose to the anus. This anastomosis, however, involved heavily irradiated tissue.

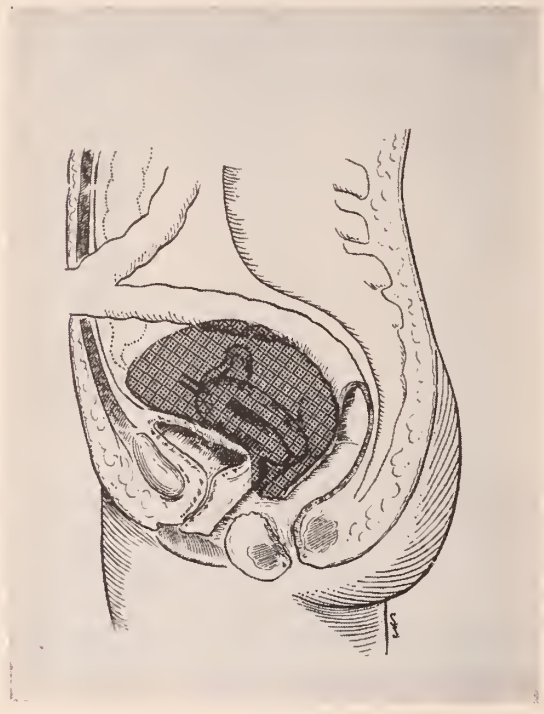


Figure 1

Shows the rectovaginal fistula and the sigmoid colostomy; in the shaded area, the large palpable mass containing uterus, parametria and considerable amount of granulomatous tissue.

Histologic examination of the specimen showed fibropurulent changes but no cancer. During the postoperative course, there was no transfusion reaction, but the sigmoid canal anastomosis broke down and seepage into the abdominal cavity with generalized peritonitis ensued.

On April 4, 1955, transverse colostomy and abdominal drainage were done as emergency measures. Marked improvement followed. Shortly after, as soon as the pain stopped, the patient abruptly stopped requesting narcotics; no withdrawal symptoms ensued, and use of narcotics was permanently suspended.

The general strength of the patient improved but she remained with a large rectovaginal fistula and a transverse colostomy. As the tissues in the perineal anal region were permanently affected by irradiation, attempts to close the rectovaginal fistula on September 29, 1957, and on December 9, 1957, were not fully successful. On April 1, 1958, however, closure of the fistula, involving use of a skin flap placed into the residual vagina, was successful. On May 20, 1958, the transverse colostomy was taken down (Figure 2). Following this procedure the patient had normal bowel movements per rectum, she was continent of urine, and her general condition was good.

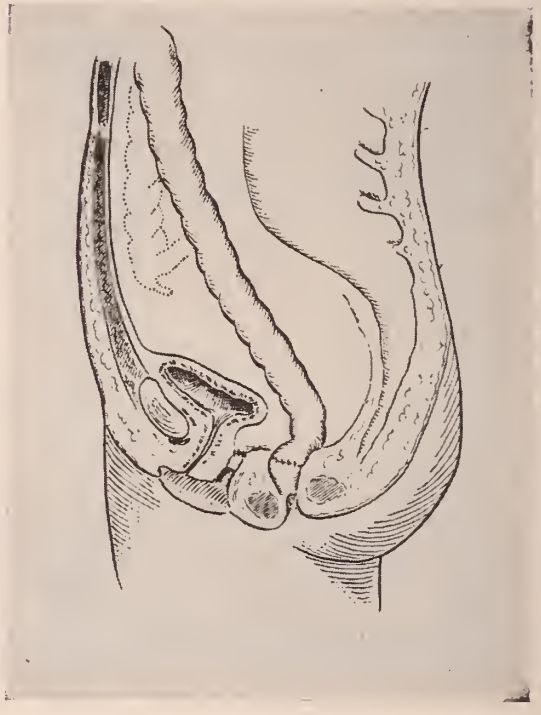


Figure 2

The mass is excised; a section of the sigmoid and the rectum, carrying also the sigmoidostomy, excised; rectovaginal fistula repaired and sigmoidorectal anastomosis affected.

Following her discharge on May 30, 1958, she rapidly improved. Her rehabilitation improved to the extent that she took a permanent position as a motel clerk.

On January 29, 1962, she was rehospitalized and a granuloma was excised from the abdominal wall in the region of one of the scars. No residual tumor was found in this granuloma. On periodic physical examination there were no objective findings, nor any suggestion of recurrent malignancy. Her general condition continued to be satisfactory until September, 1968, when she suffered a cerebral thrombosis.

Carcinoma of the cervix is the second most common form of cancer[1] in women in the United States. Although radio-therapy remains the outstanding treatment, this is not without serious complications. For this reason and also for eventual recurrence of the ori-

ginal tumor, close follow-up of such patients is important.[3]

The ionizing action of radiation delivered to the tissues probably causes some damage to all pelvic organs.[2] Sometimes it is impossible to treat the growths effectively by radiation without causing severe damage to the adjacent normal organs; late reactions or injury may appear several months or years thereafter.

Signs and symptoms of fibrosis, rectovaginal or vesicovaginal fistula, and enteritis, with or without bowel obstruction, resulting from the radiation therapy, may mimic those of recurrence of the original condition.[2,4,5] If these actinic complications are erroneously assumed to be recurrent malignancy, there is danger that additional radiation may be administered, thus causing further damage to the already injured intestine. Also serious is the danger of addiction from humanitarian administration of narcotics[6] for what is mistakenly believed to be terminal cancer.

Since these complications are often amenable to surgical corrections, their recognition may be lifesaving.

Summary

A case of carcinoma of the uterine cervix and subsequent drug addiction is reported. Following radiation therapy, multiple complications (including rectovaginal fistula, bowel obstruction, and a large abdominal mass) arose, which led to the erroneous diagnosis of extensive and inoperable recurrent cancer. Continued observation, and reexamination led, fortuitously, to the decision to subject the patient to exploration and to possible curative surgery. This was carried out by serial operations, with salutary results. Despite continued administration of large amounts of narcotics for a long period of time, no withdrawal symptoms followed discontinuance of opiates after her pain had been relieved by surgery.

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520 Rahway Avenue

The Absurd X-ray Scare

The American College of Radiology, defending the current use of x-rays by physicians, criticized recent scare stories for causing fears of x-ray examinations. Dr. R. H. Chamberlain said that articles like the one in a recent *Ladies Home Journal* distorted the facts and simply scared people as to the possible effects of being x-rayed. Dr. Chamberlain added:

"The risks to patients in the performance for medical x-ray examinations are vanishingly small. Diagnostic x-ray examinations do not endanger the health of patients. We could cite millions of instances where x-ray examinations provide life-saving information to patients. The real tragedy occurs when any individual, misled by such stories, refuses a needed examination".

Unexpected loss of consciousness is a problem to the patient and the physician. An orderly method of study is here presented.

Syncope

A Plan for Differential Diagnosis

Albert Abraham, M.D./Morristown

Syncope, momentary loss of conciousness, is frightening to patients and disturbing to physicians. Especially interesting are the physiologic mechanisms, because some can be explained and the people helped. Here, now is a plan for the study of syncope based upon my experiences with 68 patients. The proportion of males (75 per cent) reflects the fact that I served as cardiologist to a Veterans Administration Hospital and therefore saw large numbers of referred males.

A large proportion of these patients have central nervous system disease. This may be a function of the kind of patients referred to me from the Veterans Administration Hospital (a neurologic and psychiatric one) during the early part of this series. When I entered private practice, there was no neurologist or neurosurgeon practicing in the area. Consequently, some private patients who later were found to have central nervous system disease were referred as well.

I am applying the word syncope to brief episodes of loss of consciousness. A review of my 63 patients reveals that in most instances a specific diagnosis was possible: Therefore, an approach to management was possible too. (See Table I)

Table I

Distribution of Patients in this Series

MALE — 47		*FEMALE* — 16
Age	*Diagnosed*	*Diagnosed*
11-20	2	2
21-30	7	5
31-40	8	1
41-50	4	2
51-60	14	1
61-70	3	1
71-80	0	1
Total	38	13

Table II

Diagnoses in this Series

Disease of Central Nervous System	8
Epilepsy (idiopathic)	4
Brain Tumor	2
Cerebral atrophy	1
Hypertensive encephalopathy	1
Cardiovascular Disease	18
Stokes-Adams syndrome (heart block)	7
Paroxysmal tachycardia	3
Congenital aortic stenosis	2
Idiopathic hypertrophic subaortic stenosis	1
Rheumatic valvular disease	4
Cerebral Aneurysm	1
Physiologic Factors	21
Functional hyperinsulinism	8
Carotid sinus hypersensitivity	7
Cough syncope	3
Orthostatic hypotension	1
Vasovagal reflex	1
Hyperventilation	1
Emotional Mechanisms (after adequate study)	4

Table III gives the distribution of the best diagnostic clues. This points up the desirability of doing systematic studies. A number of them are simple clinical procedures.

Table III

Distribution of Best Diagnostic Clues in This Series

Electrocardiogram	10
Patient's history	8
Carotid sinus pressure test	7
Cardiac auscultation	5
Insulin tolerance test	5
Electro-encephalogram	5
Glucose tolerance test	3
Pneumo-encephalogram	3
Cerebral angiogram	3
Hyperventilation test	1
Flack test (orthostatic hypotension)	1
Total	51

These patients need a meticulous general history and physical examination. The history is often significant. In my series, for eight patients, the history was the best diagnostic clue. I would be especially interested in the age of onset, previous history of central nervous system disease, and dietary intake. A descrip-

tion of the first episode may be diagnostic; the characteristics of later episodes may change. Environmental settings, temperature, and humidity should be elicited and one should seek a history of "premonition."

The physical examination is important because one might immediately find the difficulty in some patients. For example: A loud systolic murmur at the second right sternal border might suggest aortic stenosis. A cardiac arrhythmia would be suspicious of itself. Clinical evidence of hyperthyroidism might orient one to look out for an arrhythmia, and the electrocardiogram may reveal the diagnosis.

Certain standard laboratory procedures should be done for every patient: For example: urinalysis, complete blood count, blood sugar. Spinal fluid examination and special manometric procedures are occasionally helpful.

The Carotid Sinus Pressure test may be helpful. This was positive in seven patients of this series. The test is done as follows: The patient sits in a chair, at ease, with an electrocardiogram attached and blood pressure cuff applied, and with atropine sulfate grains 1/75 in a syringe nearby. The examiner stands behind with a hand on each side of the patient's neck and gently taps the right carotid sinus three times while the electrocardiogram is recorded. If there is no response he taps the left side three times. If there is no response, he may massage the right carotid sinus for 30 seconds, later the left for 30 seconds; or after a one minute pause, both carotid sinuses simultaneously massaged for 30 seconds. AV block, diminished heart rate, or syncope would

SECTIONS FROM CONTINUOUS CARDIOGRAM

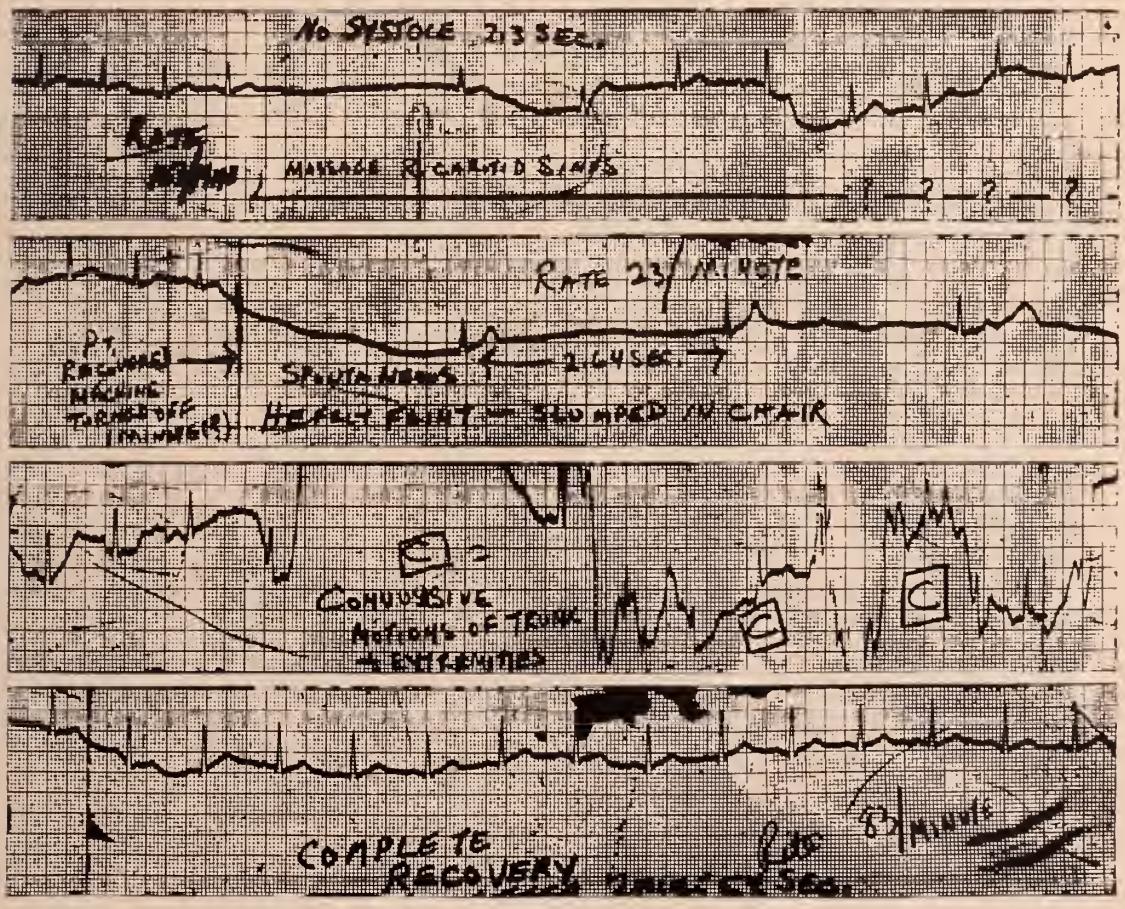


Figure 1

be considered positive signs. Hypersensitivity of the carotid sinus to pressure may be the basis of syncope through three possible mechanisms: (1) Reflex stimulation of the vagus nerve can produce temporary complete heart block and syncope; (2) Reflex stimulation of the vaso-depressive nerve fibers may produce acute dilatation of visceral muscle blood supply with pooling of blood, drop in blood pressure, and consequent syncope; (3) Reflex stimulation of specific vaso-depressive nerve fibers may produce acute dilatation of intracranial blood vessels, a sharp drop in cranial blood pressure, and consequent syncope.

An example of this type of study is reproduced in figure I.

The Flack Test is performed as follows: The patient stands at ease with a blood pressure cuff attached to one arm and an electrocardiogram attached to his body. Have atropine sulfate 1/75 in a syringe ready for use if necessary. The patient is given a rubber tube attached to a mercury sphygmomanometer. After deep inspiration he blows into the tube to push the mercury as high as possible (above his diastolic blood pressure). A sudden collapse and loss of consciousness is a positive sign. Orthostatic hypotension is considered to result from failure of the neurovascular reflex mechanism. This failure allows blood to pool in the lower extremities and abdominal viscera with the resultant drop in blood pressure. Syncope may result from moderate peripheral dilatation that develops after remaining erect in one position for a long time (on the parade grounds, e.g.).

Hyperventilation with dissipation of carbon dioxide and loss of normal respiratory stimulus may result in apnea with syncope. A simple test may be performed in this fashion: The patient should stand at ease and breathe quietly, then on direction he should breathe deeply 30 times per minute for three minutes. The resulting apnea may produce syncope which will be obvious.

Functional Hypoglycemia is a rather common disturbance. Eight patients in this series had it. One may suspect this from the history. A simple method of study would be to give a fasting patient 100 Grams of glucose and take a blood sugar (fasting and hourly for 6 hours after the glucose was administered). When possible simultaneous electroencephlogram study may be helpful. In some cases where the patient does not like to take a large amount of sugar by mouth (and it is nauseating to take 100 Grams of sugar) an insulin tolerance test is easily done. The patient fasts, fasting blood sugar is taken, he is given one unit of insulin intravenously for each 22 pounds of body weight. Half an hour later another blood sugar is taken and note is made of the patient's situation. If he is sweaty, weak, apprehensive (usual insulin type reaction) or has lost consciousnss the test could be considered positive.

An example of this kind of study is reproduced in figure II.

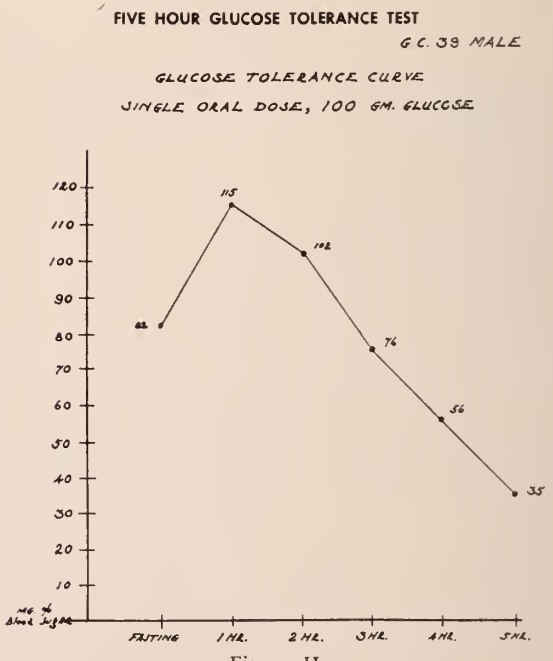


Figure II

Extensive investigation of the central nervous system could include electroencephlogram, skull x-ray films, arteriograms, brain scans, and pneumoencephlograms. The best plan would be to proceed step by step with these tests in mind where central nervous system disease is a possibility and there are no obvious neurologic abnormalities.

230 South Street

How does a general hospital prepare its emergency department for large scale emergencies? Here's how . . .

Is Your Hospital Prepared For Emergencies?

Jack R. Karel, M.D./Hillside*

The emergency department of a general hospital is the most important area in the institution. It should be separate from any other major department. More people contact the institution through the emergency room than through any other department of the hospital.[1] Law enforcement and public safety are tied up with the emergency department. There is an influx of patients of all kinds and from all economic and social levels. The emergency area and its personnel should be a department of the hospital equivalent to other departments in the matter of representation on medical boards and its administration. This unit must be adequately staffed by trained personnel, both professional medical and para-medical, and adequately equipped with expendable and non-expendable equipment and supplies to cope with all major or minor disasters, whether an industrial explosion, fires, car accidents, victims of a train wreck, heart attacks, or poisonings, and also in floods, hurricanes, earthquakes, and tornadoes, where a greater number of casualties would occur. By having a daily on-going program in the emergency department and with adequate planning and preparation, the general hospital will be ready for the onslaught that would come when victims of disaster in any community came to the doors of an emergency department. When ten or more victims of a disaster are brought to a hospital with injuries needing immediate treatment and admission, the normal operation of that hospital can be temporarily disrupted if inadequately prepared. For this case-load the emergency department will immediately need additional personnel. If thirty or more victims of disaster are brought to the hospital emergency rooms, additional space, supplies, and personnel would be required.

On March 19, 1967 the Trustees of The Medical Society of New Jersey recommended the implementation of an Emergency Medical Care Program in every general hospital in the State of New Jersey.[2] *These programs must be daily on-going in emergency departments, not crash programs.* Much has been accomplished since then. Emergency departments have been updated with improvement or replacement of the physical plant. Licensed physicians have been placed in emergency departments, either full or part-time, to provide 24-hour coverage. Fourteen hospitals have signed contracts with the Division of Emergency Health Services of the U.S. Public Health Service for the implementation of the Hospital Reserve Inventory Disaster Program at their hospital. An additional 18 hospitals have contracts pending for their participation. Also, 28 Packaged Disaster Hospitals (200-bed capacity) have been assigned to 28 community hospitals throughout the state.

The Trustees approved a recommendation of its Special Committee on Emergency Medical Care that a training program for emergency room physicians be held and repeated in each judicial district of The Medical Society of New Jersey.[3] This training program is being conducted during a ten-week period in ten of the larger general hospitals and the response has been excellent. This is the first formal program of its kind on an extensive scale to be held in the United States. The Medical

* Dr. Karel is Chairman of the Committee on Emergency Medical Care of MSNJ.

Society of New Jersey is conducting this most important program in cooperation with the New Jersey Department of Health and the Division of Emergency Health Services of the U.S. Public Health Service. Other cooperating medical organizations are the New Jersey Trauma Committee of the American College of Surgeons, New Jersey Heart Association, New Jersey Chapter, American Academy of Pediatrics, Council on Mental Health of The Medical Society of New Jersey and the New Jersey Neuropsychiatric Association. All lecturers are New Jersey physicians and surgeons.

Subjects and demonstrations included in the training program for emergency room physicians are as follows:

1. Cardiac emergencies, including pulmonary edema
2. Psychiatric emergencies
3. Infant emergencies
4. Cardio-pulmonary resuscitation
5. The unconscious patient
6. Care of simple wounds
7. Management of multi-system injury
8. Treatment of burns
9. Resuscitation, to include restoration of airway, shock, hemorrhage, and fluid replacement

A similar in-service training program ought to be held annually in every general hospital in the United States. In this way we can deliver emergency medical services properly and adequately.

Huntley[4] has stated that hospitals must be ready to call for assistance (in the event of a major disaster) from those governmental agencies charged with assuring the availability of health services to United States citizens in a disaster. Already certain programs have been established by the Division of Emergency Health Services, USPHS, not only for ready availability, but for immediate transport to the stricken area and to the hospital giving service to that area. In the first crucial hours of a disaster, there is no time to wait for outside assistance to arrive. Hospitals in the disaster area will be faced with mounting numbers of casualties and dwindling supplies of critical medical items. United States hospitals seldom maintain large inventories of expendable items because resupply under normal conditions is very easy. During a disaster, with the breakdown of communication and transportation, resupply could become difficult if not impossible. Huntley[4] has further explained that the Division of Emergency Health Services has formulated a program to expand community hospital stocks of critical medical items to a 30-day level. This is the "hospital reserve disaster inventory." Medical supplies have been taken out of the nation's emergency medical stockpile now in warehouses and placed at the point of use before they are needed. Each hospital will use the items supplied by the inventory expansion program and, at the same time, continue its established rate of procurement. This will help to assure disaster readiness and will also achieve an automatic rotation of limited shelf-life items.

Summary

The emergency department has attained importance that demands its administration as a separate department of the hospital, that it be adequately staffed by medical personnel, both professional and para-medical, and that there are adequate and available supplies and equipment to cope with all major and minor disasters. I further recommend an annual in-service training program for emergency room physicians in every general hospital.

Bibliography

1. AMA National Conference on The Community and Emergency Medical Services, January 18, 1968.

2. Trustees' Minutes, *The Journal* of the Medical Society of New Jersey, 64:5 (May 1967)

3. Trustees' Minutes, *The Journal* of the Medical Society of New Jersey, 65:12 (December 1968)

4. Huntley, Henry C., *International Surgery*, 47.3 (March 1967)

115 North Avenue

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 20, 1969

A regular meeting of the Board of Trustees was held on July 20, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Report of Treasurer . . . Authorized, in accordance with the Bylaws (Chapter 10, Section 3a), transfers between budgetary accounts to accommodate five budgetary appropriations which had been exceeded during fiscal year 1968-1969.

AMA Committees . . . Directed that the following names be submitted to the AMA for consideration in filling the December 1969 vacancies on certain committees: *Automotive Safety* — Seymour Charles, M.D., Newark, and Arnold N. Constad, M.D., Springfield; *Medicine and Religion* — Jerome G. Kaufman, M.D., Maplewood, and Bishop James G. Schad, Haddon Heights.

Medical Advisory Committee to Medicaid . . . Designated, at the request of the New Jersey Department of Institutions and Agencies, the following to serve on the Medical Advisory Committee to the State Medicaid Program:

Donald P. Burt, M.D., Morristown
Arthur C. Dietrick, M.D., Mount Holly
John D. Franzoni, M.D., Trenton
Samuel J. Lloyd, M.D., Trenton

Congress on Occupational Health . . . Authorized the attendance (with expenses paid) of Dr. Joseph A. Lepree (Chairman of the Committee on Occupational Health, Workmen's Compensation, and Rehabilitation) at the 29th Congress on Occupational Health to be held in St. Louis on September 15 and 16, 1969.

Clarification of Bylaws — Chapter V, Section 3d . . . Referred Section 3d of Chapter V of the Bylaws to the Committee on Revision of Constitution and Bylaws for clarification, by proposed amendment and subsequent report to the Board. This section concerns filling a vacancy which exists when a member who holds an elective office is elected to a second office.

Implementation of Resolution #7 (Chiropractic) . . . Conferred with representatives of Bergen County (Richard B. Berlin, M.D. and James S. Todd, M.D.) concerning actions initiated or contemplated by the Bergen County Medical Society in attempted implementation of Resolution #7 (Chiropractic) adopted as amended by the 1969 House of Delegates. It was pointed out that the resolution assigns to The Medical Society of New Jersey responsibility for its implementation, and accordingly the Board of Trustees, on May 21, 1969, referred the resolution to the Council on Legislation. (See page 530 of these minutes, under *Council on Legislation*) It is the function and responsibility of the Board to act in furtherance of all official actions taken by MSNJ. Component societies, understanding this, are expected to cooperate and keep the Society apprised of their activities. To establish better liaison, invitations should be extended to the President, Trustees, and the Executive Director to attend meetings of component societies.

Council on Legislation . . . Approved the report of the June 26 meeting of the Council on Legislation, including the following recommended official position of MSNJ on bills of medical import:

1. Bills —

S-744—To permit licensure of non-citizen applicants, after examination, who have declared their intention of becoming United States' citizens by the Board of Certified Public Accountants, Dentistry, Mortuary Science, Medical Examiners, Shorthand Reporting, Veterinary Medical Examiners, and the New Jersey Real Estate Commission. (Identical with S-508 of last year, signed into law as Chapter #144 of the laws of 1968.) *NO ACTION*

S-747—To provide for more stringent filing and reporting requirements under the Lobby Registration Act. *NO ACTION*

S-749—To provide that grounds for refusal to grant or suspend or revoke licenses to practice medicine, surgery, or chiropractic shall include violations of any provision of the act or any rule, regulation, code of ethics promulgated by the Board of Medical Examiners or where a practitioner is found guilty of unprofessional, dishonorable, or unethical conduct. *DISAPPROVED,* because it would permit the State Board of Medical Examiners to usurp the function of the medical profession in the area of the standards of medical ethics and conduct. The proper area of concern and jurisdiction for the State Board of Medical Examiners is the area of law.

S-769—To establish in the Department of Health a program for the care of persons suffering from chronic renal diseases; to provide for an advisory committee and to appropriate $250,000. (Signed into law 5 June 1969) *APPROVED*

A-891—To direct the Commissioner of Institutions and Agencies with the advice and assistance of the Narcotics Advisory Council to esablish a program for the treatment and rehabilitation of drug addicts who are inmates of correctional institutions; and to establish guidelines for use by freeholders in preparing similar programs for inmates of county jails, workhouses, or penitentiaries. *NO ACTION* (because the Society is on record already as approving A-271 of this year, which would establish a Division of Narcotic and Drug Abuse Control in the Department of Health.)

A-903—To empower the Governor to do all necessary things to insure that all State departments and local political subdivisions secure full benefits available under the National Highway Safety Act and to prepare a comprehensive plan to reduce traffic accidents under the New Jersey Highway Safety Program. *APPROVED*

A-920—To authorize the Public Health Council of the Department of Health to prescribe standards for the establishment and maintenance of solid waste collection and solid waste disposal whether by means of sanitary landfill, incineration, composting, or any other process, method, equipment, or device. *APPROVED*

A-921—To create an Advisory Committee on Solid Waste Collection and Disposal in the Department of Health, which shall review and evaluate the effectiveness, efficiency, and economy of techniques of collection and disposal of solid waste and recommend programs of research and development, including pilot projects, demonstrations, and experiments for the purpose of testing and evaluating such techniques in actual working conditions. *APPROVED*

A-924—To provide that unauthorized persons who practice medicine or surgery without first having obtained a license are disorderly persons. *DISAPPROVED,* because sanctions of existing law are adequate to protect the public against the unauthorized practice of medicine and surgery or any violation of the Medical Practice Act. Moreover, many of the provisions of present law deal with technicalities the violation of which should not warrant stigmatization of the offender as a disorderly person.

A-932—To provide that the Commissioner of Institutions and Agencies shall not issue a certificate of approval for operation of narcotics treatment centers unless he is satisfied that proper care complying with standards can be performed; and to provide that the State Board of Control of the Department of Institutions and Agencies shall adopt, promulgate, and enforce such other rules and regulations deemed necessary. *NO ACTION* (because the Society is on record as approving A-271 of this year, which would establish a Division of Narcotic and Drug Abuse Control in the Department of Health.)

A-944—To establish a renal dialysis program in the Division of Chronic Illness Control. *APPROVED*

A-945—To redesignate the Commission for the Blind as the "Commission for the Blind and Visually Handicapped." *APPROVED*

A-951—To include in the definition of optometry one who sells at retail to the general public spectacles or eyeglasses containing other than plano lenses; to provide that nothing in the definition of optometry shall prohibit a duly licensed ophthalmic dispenser from providing eyeglasses as prescribed by an optometrist or physician. *DISAPPROVED,* because the vending of such glasses is not proper or exclusive to the practice of optometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and is discriminatory.

A-953—To exempt from taxation all real and personal property used by religious, charitable, or hospital organizations for providing group housing facilities for persons 60 years of age or over. *NO ACTION*

A-961—To require the Department of Institutions and Agencies to notify the Senate and General Assembly Appropriations and Institutions and Welfare Committees and the Legislative Budget and Finance Director at least 90 days prior to the adoption and announcement of any change in the basic formula upon which assistance grants are determined for any public or general assistance program. *NO ACTION*

A-974—To prohibit thermal discharges into any waters of this State except under approved conditions. *APPROVED*

A-989—To define "qualified applicant" under the medical assistance act to include a child in foster placement under supervision of the Bureau of Children's Services whose maintenance is being paid in whole or part from public funds; and to permit any approved claims for health services rendered on or before December 31, 1969 to recipients of old age assistance, assistance for the permanently and totally disabled, assistance for the blind, or for dependent children to be paid on or before June 30, 1970. *APPROVED*

A-990—To delete the one year state residency requirement for old age assistance and to eli-

minate ineligibility for such assistance on the basis of residency in any public or private medical institution other than a hospital. *APPROVED*

A-991—To provide that medical assistance for the aged shall be administered by the Department of Institutions and Agencies; to provide for a hearing when a claim for medical assistance is denied or not acted upon promptly; to provide that the State shall provide funds to meet expenditures; to provide that the State shall pay reasonable costs incurred by county welfare boards in investigating and determining whether applicants are eligible for aged medical assistance under standards prescribed by the Department of Institutions and Agencies. *APPROVED*

A-1005—To provide that whenever a related individual has reason to believe any person is a narcotics addict such related individual may file a petition with the county clerk requesting that such person he admitted to a hospital for treatment of his addiction *APPROVED*

A-1006—To include hallucinogenic drugs under the depressant or stimulant drug law; to prescribe penalties for the illegal use of LSD and other hallucinogens. *APPROVED*

A-1007—To provide that no motor vehicle dealer shall sell any used motor vehicles unless such vehicles, exclusive of tires, meet the standards for issuance of a certificate of approval. *APPROVED*

A-1020—To require the annual licensure of all clinical laboratories by the State Department of Health; to direct the Department of Health to establish and conduct a clinical laboratory evaluation program; to authorize the Public Health Council to promulgate rules and regulations for operation of clinical laboratories. *DISAPPROVED* (While the Council on Legislation approves the purpose of this legislation, it does not approve the bill as drawn.)

NOTE: Milton Ackerman, M.D., representing the New Jersey Society of Pathologists, informed the Council that although the Society of Pathologists is in favor of legislation which will license and regulate clinical laboratories, it does not believe A-1020 is a satisfactory way to achieve it for the following reasons:

1. The bill places unregulated, unrestricted, and unsupervised authority in the hands of the Director of the Division of Laboratories of the New Jersey State Department of Health.

2. The bill is loosely drawn, since it not only includes statutory matters, but matters which would more readily fall into the State Sanitary Code.

3. The bill is discriminatory in that it would require licensure of laboratories operated by groups of practicing physicians performing laboratory tests on their own patients when such laboratories of more than four physicians constitute the group. It also forbids work done on behalf of referred patients.

4. The bill designates the Public Health Council as the advisory board to the administrator. This would be a completely inadequate agency for controlling the administrator of such a broad and far reaching measure. There should be a fully qualified advisory council of some type with broad powers to insure effective administration.

5. The bill provides for penalties for physicians who may, "in the language of the bill," be considered to be fee-splitting, or assuming other unearned remuneration in the laboratory charges for patients on whom they have referred laboratory studies to licensed laboratories.

6. The bill gives the administrator (i.e., the laboratories of the New Jersey State Department of Health) the right to refuse to make or to charge for serological studies on materials submitted to the laboratory of the State Department of Health by physicians of the State.

As a result of the foregoing, the Council agreed to inform the sponsors of A-1020 of its willingness to arrange a conference between the sponsors and representatives of the New Jersey Society of Pathologists for the purpose of evolving constructive changes in the proposed legislation to make possible approval of it by The Medical Society of New Jersey.

A-1021—To authorize the Department of Health to conduct a survey of nutritional deficiencies in the State with special attention to nutritional needs of infants and pregnant women; to appropriate $75,000. *APPROVED*

A-1054—To require boards of education to retain an optometrist or a diplomate of the American Board of Ophthalmology licensed to practice medicine and surgery. *ACTIVE OPPOSITION*, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or ophthalmologist would, in consequence, be an unjustifiable and expensive redundancy. Moreover, it is discriminatory against qualified ophthalmologists who are not Diplomates of the American Board of Ophthalmology *and against all other fully licensed phsyicians.* (Underscoring indicates amendment by the Board of Trustees.)

AJR-14—To create a commission to study the nature, extent, and amount of State aid and State facilities for the care of mentally retarded and disturbed persons. *APPROVED*

SJR-17—To create the Professional and Occupational Licensing Study Commission to evaluate and make recommendations for overseeing those professions and occupations which require licensing to protect the public interest.

NOTE: The Council gave special consideration to SJR-17, which was signed into law as J. R. 8 on 27 May 1969. The Council then *recommended* that a letter be sent to the Governor, over the signature of the President, requesting that a representative of this Society be a member on the Professional and Occupational Licensing Study Commission.

The Council considered the following bills and *recommended* that they be "noted and filed" as not being of intimate concern at this time:

S-774—To permit freeholders, after public hearing and by ordinance, to establish county boards of health.

S-776—To permit contiguous municipalities in one or more counties to create consolidated local health districts and to provide procedures therefor.

S-794—To define "milk" and to authorize the Commissioner of Health to establish rules and regulations to govern standardization of milk and establish specific labeling requirements.

A-957—To direct the State Medicaid Commission to approve and accept the lowest responsible bid submitted under the New Jersey Medical Assistance and Health Services Act (Section 8a) whether said bid was heretofore or hereafter submitted.

ACR-80—To create a commission to study the extent of and controls against child abuse.

ACR-84—To request the Commissioner of Education to advise local boards of education not to initiate programs of sex education during pendency of legislative inquiry into policy questions connected therewith.

2. Referrals from the Board —

a. *Legal right of optometrists to perform corneal tonometric examinations and, in the process, to instill anesthetic drops into the eyes.*

The Council received and noted this referral from the Board and was informed by the Executive Director that the Society was waiting to hear from the Academy of Ophthalmology and Otolaryngology for the names of their two representatives.

b. *Elimination of future licensing of Chiropractic in the State — Resolution #7*

In considering Resolution #7, the Council directed that the Legislative Analyst prepare a draft of legislation to effect the discontinuance of licensing of Chiropractic in this State. Also, the Council *recommends* to the Board of Trustees that at the proper time they send an official communication to the Governor and the Legislators setting forth the Society's thinking and recommendations in this regard.

c. *Revision of FAA Medical Examination Form for Pilot Certification*

In 1968 the House of Delegates adopted a resolution that called for the revision of the FAA medical examining form so as to grant immunity from suit to the examining physician. The Medical Society of New Jersey corresponded directly with the FAA urging the foregoing change and was subsequently informed that legislation to effect that purpose was being drafted.

The 1969 House of Delegates directed that a follow-up be made to insure passage of this legislation. The matter was referred to the Council on Legislation.

The Council *recommended* that a letter over the signature of the President or Secretary of The Medical Society of New Jersey again be sent to the FAA urging sustained support of this legislation and that a copy of this letter be sent to the AMA with a request that it use its influence to bring the legislation to enactment.

d. *Amend Abortion Laws — Resolution #6*

The Council received as informative at the present time Resolution #6, which directs that The Medical Society of New Jersey's official position in regard to the abortion laws include two paragraphs from the Maryland Law on abortion. These two paragraphs have already been furnished to the New Jersey Commission studying the abortion laws.

Medical Defense and Insurance . . . Approved the report of the July 9 meeting of the Committee on Medical Defense and Insurance, including the following recommendations:

1. That the Committee on Medical Defense and Insurance reaffirm its earlier position that individuals more than 50 per cent of whose practice is outside of New Jersey and physicians in the military service be *not* covered under the Society's regular program.

2. That if Mr. Britton (in his capacity as an independent insurance broker) desires to make other coverage available to these physicians, he should be free to do so, but not as the official broker for the Society's program.

3. That in the event that this coverage is provided by Employers Insurance of Wausau, request be made of the company to supply a letter to MSNJ assuring the Society that any incidents that arise with physicians covered under this separate policy will not be included in the computation of MSNJ's loss experience under its official program.

4. That timely releases reflecting recent loss experience and other significant data be printed in the *Membership Newsletter* and that the material to be printed be provided through the cooperation of Doctor D'Elia, Mr. Nevin, Mr. Maressa, and Mr. Britton.

5. That Mr. Britton be authorized to function as Coordinator of meetings of county medical review and advisory committees with representatives of American Mutual and/or representatives of Employers Insurance of Wausau on schedules acceptable to the county committees.

Annual Meeting 1970 . . . Approved the reports of the June 8 and June 22 meetings of the Annual Meeting Committee, including the following suggested daily schedule:

Friday, 15 May 1970
4:00 p.m.—Board of Trustees
7:00 p.m.—Buffet Dinner

Saturday, 16 May 1970
10:00 a.m.—Registration Opens
1:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for GMA Recipients and their families
3:00 p.m.—House of Delegates
4:30 p.m.—Nominating Committee
7:00 p.m.—Officers' Dinner

Sunday, 17 May 1970
9:00 a.m.—Registration Opens
9:30 a.m.—Scientific Sessions
10:00 a.m.—Exhibits Open
10:00 a.m.—Coffee meeting with Reference Committee Chairmen
10:45 a.m.—Reference Committees
1:00 p.m.—Scientific Sessions
3:30 p.m.—House of Delegates (election)
followed by addresses of outgoing and incoming Presidents (General Session)
6:00 p.m.—Inaugural Reception
8:00 p.m.—Reception-Buffet for Technical Exhibitors

Monday, 18 May 1970
9:00 a.m.—Registration and Exhibits Open
9:30 a.m.—Scientific Sessions
2:00 p.m.—Scientific Sessions
7:00 p.m.—Annual Dinner-Dance

Tuesday, 19 May 1970
9:00 a.m.—Registration and Exhibits Open
9:00 a.m.—House of Delegates
(luncheon recess, if necessary)
3:00 p.m.—Registration and Exhibits Close

Wednesday, 20 May 1970
8:30 a.m.—Board of Trustees

. . . Directed that suggestions that medical students in New Jersey schools be contacted directly urging them to visit our convention, and that the Editor of THE JOURNAL consider publishing a "student issue" be referred back to the committee for action at its discretion.

. . . Approved the Committee's recommendation that following the fall meeting of the MSNJ scientific section officers, each specialty society be invited to set up scientific meetings for 1971 to coincide with our annual meeting, with the Academy of Medicine acting as the steering force.

. . . Referred to the Committee on Revision of Constitution and Bylaws an action of the Annual Meeting Committee that a study be made to the end that changes be made in the Bylaws which would permit broader scheduling of events, specifically Chapter V — Procedure of Election, Section 1, Nominating Committee. It was recommended that this study be undertaken prior to February 1970 so that any change could be submitted to the 1970 House of Delegates.

. . . Suggested that component societies be polled concerning the desirability of the Nominating Committee's meeting in advance of the Annual Meeting.

Journal Advertising Rates . . . Authorized a recommended 10 per cent increase in advertising rates for one page and one-half page advertisements, effective January 1, 1970.

Woman's Auxiliary . . . Approved, on recommendation of the Advisory Committee to the Woman's Auxiliary, the Auxiliary program for 1969-1970, which is substantially the same as that of 1968-1969.

Prevention of Motorcycle Accidents

Last year almost 1,600 people died in motorcycle accidents. More than half of them were due to head injuries, and most of the head injuries would have been prevented or made trivial if the motorcyclist had simply worn a protective helmet and goggles. Doctors whose practice includes enthusiastic motorcyclists are urged to remind them of this simple fact; and it is hoped that this advice will be taken more seriously than much of the advice on cigarette smoking.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during July:

	July 1969	July 1968
Aseptic meningitis	12	21
Primary encephalitis	2	2
Hepatitis, total	158	115
Infectious	139	86
Serum	19	29
Malaria (all military)	13	9
Meningococcal Meningitis (two military)	3	16
German Measles	6	11
Measles	52	58
Salmonella	38	73
Shigella	20	23

Ritter's Disease

On May 29, the Division of Preventable Diseases investigated an outbreak of staphylococcal dermatitis in a newborn nursery. Many of the infants manifested evidence of Ritter's Disease, which is acute epidermal necrolysis. This usually develops as a local hyperemia that quickly progresses to the formation of bullae or wrinkling and then exfoliation. The denuded areas are erythematous and moist. The process usually begins as perioral erythema followed by widespread involvement. Nikolsky's sign is characteristic. Fever and monocytosis are variable findings. Histopathologic sections show necrosis and sloughing off of the epidermis without dermal involvement. Before antibiotic therapy, the mortality rate was about 50 per cent.

Ritter's Disease in children and neonates is infectious. Hemolytic staphylococcus is the etiologic agent most often incriminated. The mechanism by which staphylococcus *aureus* causes this exfoliative dermatitis is obscure, although production of an erythrogenic toxin has been hypothesized.

In the present outbreak, 78 infants were affected with a clinical spectrum ranging from simple pyoderma to Ritter's Disease. A clinical diagnosis of Ritter's Disease was made on 34 of these children. Coagulase positive hemolytic Staphylococci were cultured from 27. Phage grouping 29/79/80/3A/36/54/75 was seen in 20. Fourteen infants who did not develop symptoms were also found to have Staphyloccus *aureus* of this same "phage" type on routine culture.

Control measures begun on June 7 included closing of the affected nursey, institution of a cohort system, Phisohex® baths and Neosporin® ointment for all infants. Symptomatic babies were also treated with antibiotics systemically. Surveillance has been continued and no new cases have been reported in babies born after this date.

Rubella Vaccine

Rubella vaccine has now been licensed for public use. Vaccination against this disease should virtually eliminate it as a cause of congenital defects. Federal recommendations give priority to its use on kindergarten and early school-age children. It is also recommended for routine pediatric immunization programs in children one year of age or older when sufficient supplies of the vaccine become available.

Caution is recommended in vaccinating females of child-bearing age. Serologic testing should first be done as a routine procedure for screening out the 85 per cent in this group who are immune and need not be vaccinated. The physician must be also assured that the patient is not pregnant and will not become pregnant in the ensuing two months.

Any adverse reaction from rubella immunization should be promptly reported to the State Health Department. Arthralgia or arthritis or any other reaction associated with the vaccine should be brought to the attention of New Jersey's State Health Department. Rubella in a contact of a vaccinee is considered an adverse reaction. If the vaccinee is found to be pregnant at the time of vaccination (or in the ensuing two months) this should be considered a reportable adverse effect. Reports of adverse effects should be telephoned to 609-292-5590. Remember, please, that rubella is a reportable disease. All cases of congenital and acquired rubella should be reported to the local health department and then transmitted to the State Department of Health.

1969-70
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Lambertville

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Connecticut—Peter H. Marvel, M.D. (1970) .Northfield

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Peter H. Marvel, M.D. (1970) ..... Northfield
Robert E. Verdon, M.D. (1972) ..... Cliffside Park
Charles L. Cunniff, M.D., *Secretary*
Ex-Officio ..... Jersey City

*Scientific Exhibits

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Arthur Krosnick, M.D. ..... Trenton
Thomas K. Rathmell, M.D. ..... Trenton
John J. Thompson, M.D. ..... Caldwell
Robert E. Verdon, M.D. ..... Cliffside Park

*Scientific Program (Sections)

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Alan G. Posta, M.D., *Chairman* ..... Trenton
Mary B. Hall, M.D., *Secretary* ..... Trenton

Anesthesialogy

Arganey L. Lucas, Jr, M.D., *Chairman* ..... Dover
Bertram H. Shapiro, M.D., *Secretary* ..... Livingston

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Joseph P. Greeley, M.D., *Secretary* ..... Westfield

Dermatalogy

Martin H. Wortzel, M.D., *Chairman* ..... Millburn
William Cohen, M.D., Secretary ..... Trenton

Gastraenterolagy and Practalogy

Benjamin H. Schatman, M.D., *Chairman* .. East Orange
Herbert Z. Greenfield, M.D., *Secretary* ... East Orange

General Practice

Nelson C. Walker, M.D., *Chairman* ..... Hackensack
Edmund E. Jacobitti, M.D., *Secretary* .... Maywood

Medicine

Bascom S. Waugh, M.D., *Chairman* ..... Camden
James G. Dickensheets, M.D., *Secretary* .... Camden

Metabalism

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Jasper L. Van Avery, Jr., M.D., *Secretary*
New Brunswick

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Samuel J. Fortunato, M.D., *Chairman* .. Short Hills
Caterina Gregori, M.D., *Secretary* ..... Newark

Ophthalmalagy

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A. G. Portfolio, M.D., *Secretary* ..... Ridgewood

Orthapedic Surgery

Donald J. Holtzman, M.D., *Chairman* .... Elizabeth
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Myles G. Turtz, M.D., *Secretary* ..... South Orange

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C. Prentiss Ward, M.D., *Chairman* ..... Belleville
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Eugene V. Resnick, M.D., *Secretary* ..... Paramus

Radialagy

Leopold S. Kaplan, M.D., *Chairman* .. Highland Park
Franklin Wald, M.D., *Secretary* ..... Edison

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* Subcommittees of Annual Meeting Committee.

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Frederick Lerman, M.D., *Chairman* — Elizabeth
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Henry A. Davidson, M.D., *Editor* Ex-Officio — East Orange

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Delma W. Caldwell, M.D. Linden
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Elmer J. Elias, M.D. Trenton
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Harvey Hammer, M.D. Morristown
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Joseph J. Kline, M.D. Trenton
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Catherine Spears, M.D. Chatham
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Ira S. Ross, M.D. South Orange
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Ralph A. Skowron, M.D. — Cherry Hill
D. Blair Sulouff, M.D. — Morristown

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Calvin Hahn, M.D. — Vineland
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Paul C. Fagan, M.D. — Bloomfield
Robert S. Garber, M.D. — Belle Mead
William J. Moore, M.D. — Trenton
William L. Sprout, M.D. — Salem
Frank B. Vanderbeek, M.D. — Paterson

1969-1970 SPECIAL COMMITTEES SPECIAL/LIAISON REPRESENTATIVES

Abortion Law Study Commission

(Nine-member legislative commission to study statutes relating to abortion and the problem of illegal abortions in New Jersey.)
Hannah Seitzick-Robbins, M.D. — Trenton

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy — 6/19/66)
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David Eckstein, M.D. — Trenton
James A. Rogers, M.D. — East Orange
(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy — 11/15/64)
Morris H. Saffron, M.D., *Chairman, Committee on Medical Education* — Passaic
John A. Kinczel, M.D., *Vice-Chairman, Committee on Medical Education* — Trenton

American Medical Association—Education Research Foundation

(Liaison requested by AMA — 10/7/51)
Frank J. Hughes, M.D., *Chairman, Committee on Medical Student Loan Fund* — Gloucester

Audit Review Committee (1968-1969 Audit)

(Appointed annually by Board to review previous year's audit)
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Nicholas A. Bertha, M.D. — Wharton
Edward G. Bourns, M.D. — Westfield
William J. D'Elia, M.D. — Neptune City
I. Edward Ornaf, M.D. — Camden
Consultants:
Samuel J. Lloyd, M.D., *Treasurer* — Trenton
Thomas C. DeCecio, M.D., *Chairman, Finance and Budget Committee* — Cliffside Park

Bicentennial History

(Committee appointed to expedite distribution of history — 5/12/67)
Emanuel M. Satulsky, M.D., *Chairman* — Elizabeth
Mr. Richard I. Nevin, *Executive Director* — Trenton

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association — 4/25/69)
David Eckstein, M.D. — Trenton

Blood Bank Commission of New Jersey

(1) Formation of Commission authorized by 1953 House of Delegates
Authorized agent of MSNJ in approved Blood Bank Programs
(2) Appointment of two representatives requested by Commission — 4/5/54
Jerome G. Kaufman, M.D. — Maplewood
John J. Torppey, M.D. — Newark

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP — 4/16/60)
Thomas C. DeCecio, M.D., *Chairman, Board of Trustees* — Cliffside Park
Nicholas A. Bertha, M.D., *President* — Wharton

Mr. Richard I. Nevin, *Executive Director* . . Trenton
Equal representation from:
Medical Service Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Control, Department of Institutions and Agencies
(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D., (June 1971) . . . . . Gloucester

Board of Nursing, New Jersey State
(Liaison requested by Board of Nursing — 11/21/65)
Jesse McCall, M.D. . . . . Newton

Bureau of Investigation, Department of Law and Public Safety
(Cooperating committee requested by Department of Law and Public Safety — 9/61)
Board of Trustees

Cardiac Advisory Panel to Director of Motor Vehicles
(Panel requested by Special Commission on Traffic Safety — 9/17/61 . . . appointed by Director of Motor Vehicles)
Jerome G. Kaufman, M.D., *Chairman* . . . . Maplewood
James G. Kehler, M.D. . . . . Woodbury
Jesse McCall, M.D. . . . . Newton
John C. Wood, M.D. . . . . Trenton

Chamber of Commerce Legislative Conferences
(Invited by Chamber — 1/15/61)
Mr. Richard I. Nevin, *Executive Director* . . . . Trenton

Chronic Sick, State Advisory Council
(Commissioner of Health requested MSNJ submit names to Governor — 10/16/60 . . . appointed by Governor for 3-year term
David Eckstein, M.D. (1971) . . . . . Trenton

Civil Defense Organization, Liaison With State
(Liaison established by MSNJ — 5/22/55)
Jack R. Karel, M.D., *Chairman, Committee on Emergency Medical Care* . . . . . Hillside

Crippled Children Commission, State
(Appointed by Governor for a 5-year term)
Frederick G. Dilger, M.D. (May 1971) . . . Hackensack

Diabetes Detection Drive
(Liaison representative for annual drive — co-sponsored by State Department of Health, New Jersey Diabetes Association, and MSNJ — appointed at request of Commissioner of Health — 5/16/54)
John J. Torppey, M.D. . . . . Newark

Disputed Claims, Advisory Committee to Review MSP and HSP
(Established at request of MSP — 8/21/60 — Quorum: 4 members
1st District —
Ralph M. L. Buchanan, M.D., *Chairman* . . . . . Phillipsburg
Robert F. Zimmerman, M.D. . . . . Morristown
2nd District —
John J. Bedrick, M.D. . . . . Bayonne
Robert A. Cosgrove, M.D. . . . . Jersey City
3rd District —
John S. VanMater, M.D. . . . . New Brunswick
John A. Kinczel, M.D. . . . . Trenton
4th District —
John C. Clark, M.D. . . . . Cherry Hill
Robert S. Gamon, Jr., M.D. . . . . Camden
5th District —
A. Guy Campo, M.D. . . . . Westville
Nicholas E. Marchione, M.D. . . . . Vineland

Education, State Department of
(Liaison requested by the Assistant Commissioner of Education — 9/21/58)
William J. Farley, M.D., *Chairman, Special Committee on Child Health* . . . . . Nutley

Emotionally Disturbed Child, Advisory Council to Department of Education
(Liaison requested by the Department of Education — 10/28/68)
William J. Farley, M.D. . . . . Nutley

Epilepsy, Advisory Panel to State Director of Motor Vehicles
(Established at request of Director of Motor Vehicles — 7/29/66)
J. Berkeley Gordon, M.D. . . . . Rumson

Executive Committee
(Provided in the Bylaws, Chapter IV, Section 5 (b))
Nicholas A. Bertha, M.D., *President* . . . . Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
E. Vernon Davis, M.D., *First Vice-President* . . . . . Mount Holly
William J. D'Elia, M.D., *Second Vice-President* . . . . . Neptune City
Thomas C. DeCecio, M.D., *Chairman, Board of Trustees* . . . . . Cliffside Park

Eye Medication, Conference Committee on the Control of
(Established by Board of Trustees — 4/20/69)
Samuel J. Lloyd, M.D., *Chairman, Representative of the Board of Trustees* . . . . . Trenton
Jesse McCall, M.D., *Chairman, Council on Legislation* . . . . . Newton
Henry J. Mineur, M.D., *Vice-Chairman, Council on Legislation* . . . . . Cranford
Frank B. Vanderbeek, M.D., *Chairman, Committee on Conservation of Vision, Hearing, and Speech* . . . . . Paterson
D. Blair Sulouff, M.D., *Member of the Committee on the Conservation of Vision, Hearing, and Speech* . . . . . Morristown
Mr. E. Powers Mincher, *Legal Counsel* . Pennington
Mr. Richard I. Nevin, *Executive Director* . Trenton
Mr. Vincent A. Maressa, *Executive Assistant* . Trenton
Representatives of the New Jersey Academy of Ophthalmology and Otolaryngology
Alfonse A. Cinotti, M.D. . . . . Jersey City
John Scillieri, M.D. . . . . Paterson

Fluoridation, Joint Committee on
(Established at request of State Department of Health)
Edwin H. Albano, M.D. . . . . East Orange
Rudolph G. Matfferd, M.D. . . . New Brunswick
Equal representation from:
State Department of Health
New Jersey State Dental Society

Headquarters, Investigation of Future
(Committee established by Board — 6/19/66)
Nicholas A. Bertha, M.D., *Chairman* . . . Wharton
Samuel J. Lloyd, M.D. . . . . Trenton
Emanuel M. Satulsky, M.D. . . . . Elizabeth

Health Careers Service, New Jersey
(Physician representation established by Board of Trustees 7/20/69)
Karl T. Franzoni, M.D. ..... Trenton

Health Careers Service, Resource Persons to New Jersey
(Liaison established at request of Health Careers Service — 7/19/64)
Presidents of Component Societies

Health Facilities Planning Council
(MSNJ invited to nominate 3 members for the Board of Trustees — 2/16/64 . . . appointed by Council to serve for a 3-year term
Louis F. Albright, M.D. (1970) ..... Spring Lake
John F. Kustrup, M.D. (1972) ..... Trenton
Jesse McCall, M.D. (1971) ..... Newton

Health Insurance Conference
(Committee established at request of Health Insurance Council — 3/24/57)
Nicholas A. Bertha, M.D., *President* ..... Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
E. Vernon Davis, M.D., *First Vice-President* ..... Mount Holly
William J. D'Elia, M.D., *Second Vice-President* ..... Neptune City
Mr. Richard I. Nevin, *Executive Director* Trenton
Jerome G. Kaufman, M.D., *Chairman* ... Maplewood
Matthew E. Boylan, M.D. ..... Jersey City
Charles L. Cunniff, M.D. ..... Jersey City

Health, State Department of
(Liaison requested by Commissioner of Health — 6/6/54)
Rudolph G. Matflerd, M.D., *Chairman, Council on Public Health* ..... New Brunswick

Heart Disease, Cancer, and Stroke
University City Science Center, Philadelphia
(Established at invitation of University City Science Center — 12/65)
Louis K. Collins, M.D. ..... Glassboro

Historian-Archivist
(Created at the suggestion of the Executive Director — 1/13/57)
Morris H. Saffron, M.D. (Appointed 5/67) .... Passaic

Hospital Association, New Jersey
(Invitation extended to Executive Director to serve on the Board of Trustees — 12/17/67)
Mr. Richard I. Nevin, *Executive Director* ... Trenton

Hospital Advisory Council, State Department of Institutions & Agencies
(Appointed by the Board of Control for a 4-year term)
Luke A. Mulligan, M.D. (December 1972) ... Leonia

Hospital Service Plan Board of Trustees
(Provided in HSP Bylaws)
Nicholas A. Bertha, M.D., *President* ..... Wharton

House Maintenance, Staff Policies, and Personnel Relations
(Special Committee created by Board of Trustees — 9/21/58)
Nicholas A. Bertha, M.D., *President* Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
Charles L. Cunniff, M.D., *Secretary* Jersey City
Samuel J. Lloyd, M.D., *Treasurer* Trenton
Thomas C. DeCecio, M.D., *Chairman, Board of Trustees, and Chairman, Committee on Finance and Budget* ..... Cliffside Park

Industrial Safety Board, New Jersey
(Appointed by the Governor — 10/16/66)
Joseph A. Lepree, M.D. (7/1/71) ..... Elizabeth

Institutions and Agencies, State Department of
(Liaison established 7/16/61)
Frank J. Hughes, M.D. ..... Gloucester

Intra-Hospital Infections, Joint Committee on
(Established at request of Commissioner of Health — 4/8/62)
Edwin H. Albano, M.D., *Chairman* ..... East Orange
Lawrence Gilbert, M.D. ..... Newark
Thomas K. Rathmell, M.D. ..... Trenton
Eugene H. Kain, M.D. ..... Camden
Equal representation from:
State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

JEMPAC, Conference Committee With
(Established at request of JEMPAC — 6/25/67)
Jesse McCall, M.D., *Chairman, Council on Legislation* ..... Newton
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ... Glasshoro
William J. D'Elia, M.D., *Second Vice-President* ..... Neptune City

Judiciary and Bar, Conference Committee on Inter-Relations With the
(Established at invitation of Supreme Court—11/17/63)
Charles L. Cunniff, M.D. ..... Jersey City
E. Vernon Davis, M.D. ..... Mount Holly
William J. D'Elia, M.D. Neptune City
Joseph P. Donnelly, M.D. Jersey City
Jerome G. Kaufman, M.D. Maplewood
Samuel J. Lloyd, M.D. Trenton
Nicholas E. Marchione, M.D. Vineland
Jesse McCall, M.D. Newton
Emanuel M. Satulsky, M.D. Elizabeth
Nicholas A. Bertha, M.D., *President, Ex-Officio* Wharton
Mr. Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legal Documents, Committee on Extension to Interns and Residents of Power to Sign Certain
(Established at request of 1969 House of Delegates)
Nicholas A. Bertha, M.D., *Chairman* Wharton
Henry J. Mineur, M.D. Cranford
Emanuel M. Satulsky, M.D. ..... Elizabeth

Legislation
(1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 . . . to serve as official intermediaries between MSNJ and the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 15 Senatorial Districts/21 Component Societies

Medicaid Commission, Medical Advisory Council of the State

(Established at invitation of the State Medicaid Commission)

Louis K. Collins, M.D. ..... Glassboro

Medicaid, Negotiating Committee for

(Established by Board of Trustees to work with the State Medicaid Commission — 12/22/68)

Nicholas A. Bertha, M.D., *President* ..... Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ..... Glassboro
Associate Members:
Jesse McCall, M.D., *Chairman, Council on Legislation* ..... Newton
Henry J. Mineur, M.D., *Vice-Chairman, Council on Legislation* ..... Cranford
Leonard Brown, M.D., *Vice-Chairman, Council on Medical Services* ..... Hackensack
Francis J. Benz, M.D., *Representative of 1st Judicial District* ..... Chatham
Karl T. Franzoni, M.D., *Representative of 3rd Judicial District* ..... Trenton
Robert S. Gamon, Jr., M.D., *Representative of 4th Judicial District* ..... Cherry Hill

Medicaid, New Jersey (Citizens) Committee for

(Established at request of organization — 4/21/68)

Louis K. Collins, M.D. ..... Glassboro

Medicaid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by State Department of Institutions and Agencies — 6/12/69)

Donald P. Burt, M.D. ..... Morristown
Arthur C. Dietrick, M.D. ..... Mount Holly
John D. Franzoni, M.D. ..... Trenton
Samuel J. Lloyd, M.D. ..... Trenton

Medical Assistants, New Jersey Association of

(Liaison requested by Association — 9/15/63)

Aaron J. Heisen M.D. ..... Trenton

Medical-Hospital-Nursing Conference (Tri-Partite)

(Liaison established by MSNJ — 1/13/57)

Nicholas A. Bertha, M.D., *President* ..... Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
John F. Kustrup, M.D., *Immediate Past-President* ..... Trenton
Mr. Richard I. Nevin, *Executive Director* ..... Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)

Nicholas A. Bertha, M.D., *President* ..... Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
John F. Kustrup, M.D., *Immediate Past-President* ..... Trenton
Mr. Richard I. Nevin, *Executive Director* ..... Trenton
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)
(1) Medical-Dental
(Liaison requested by the Dental Society — 6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ — 10/25/53)
(3) Medical-Legal
(Liaison established by MSNJ — 10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ — 4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association — 9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ — 7/26/53)

Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish a

(Established by Board — 5/17/67) — Appointments by President)

Louis K. Collins, M.D., *Chairman* ..... Glassboro
A. Guy Campo, M.D. ..... Westville
Joseph P. Donnelly, M.D. ..... Jersey City
Sherman Garrison, M.D. ..... Bridgeton
Frank J. Hughes, M.D. ..... Gloucester
Jerome G. Kaufman, M.D. ..... Maplewood
John F. Kustrup, M.D. ..... Trenton
Fred A. Mettler, M.D. ..... Blairstown

Medical Schools in New Jersey, ad hoc Committee on Development of

(Established by Board — 9/20/64)

Nicholas A. Bertha, M.D., *President* ..... Wharton
Emanuel M. Satulsky, M.D., *President-Elect* Elizabeth
Joseph P. Donnelly, M.D. ..... Jersey City
Sherman Garrison, M.D. ..... Bridgeton
Jerome G. Kaufman, M.D. ..... Maplewood
Fred A. Mettler, M.D. ..... Blairstown

Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)

Nicholas A. Bertha, M.D., *President* ..... Wharton

Medicare, Committee on Utilization of Physician's Services Under Part B

(Established at request of 1969 House of Delegates)

Nicholas A. Bertha, M.D., *Chairman* ..... Wharton
John F. Kustrup, M.D. ..... Trenton
Emanuel M. Satulsky, M.D. ..... Elizabeth

Medicare Law (P.L. 89-97)

(Assigned by the Board — 10/17/65 as indicated below)
(1) Overall responsibility to study and provide recommendations concerning the Medicare Program
Council on Medical Services
Consultants to the Council on Medical Services:
Nicholas A. Bertha, M.D., *President* ..... Wharton
Emanuel M. Satulsky, M.D., *President-Elect* ..... Elizabeth
Jesse McCall, M.D., *Chairman, Council on Legislation* ..... Newton
Rudolph G. Matfferd, M.D., *Chairman, Council on Public Health* New Brunswick
Frank J. Hughes, M.D., *Member, New Jersey Board of Control* ..... Gloucester
(2) Liaison representative to State Department of Health
(Established by MSNJ — 1/16/66)
David Eckstein, M.D. ..... Trenton
(3) Liaison representative to State Department of Institutions & Agencies
(Established by MSNJ — 1/16/66)
Francis J. Benz, M.D. ..... Chatham
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ..... Glassboro
Mr. Vincent A. Maressa, *Executive Assistant* ..... Trenton
(4) Home-Hospital-Nursing Care
(Liaison established by MSNJ — 3/20/66)
Matthew E. Boylan, M.D. ..... Jersey City

Membership Directory

(Special committee established by Board — 11/19/61)
Charles L. Cunniff, M.D., *Chairman* . . Jersey City
Robert C. Anderson, M.D. . . . . Newark
John J. Bedrick, M.D. . . . . Bayonne
Matthew E. Boylan, M.D. . . . . Jersey City
George B. Sharbaugh, M.D. . . . . Trenton
Mr. Richard I. Nevin, *Executive Director* Trenton
Mr. Robert H. Lambert, *Business Manager* Trenton

Motor Vehicles, State Division of

(Liaison established at the request of the Division — 4/16/61)
Irwin S. Smith, M.D., *Chairman, Committee on Traffic Safety* . . . . . Willingboro

Neurological Diseases, Advisory Council to New Jersey Consultation Service for Convulsive Disorders

(Liaison established — 7/19/64)
Robert S. Garber, M.D. . . . . Belle Mead

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)
George E. Barbour, M.D. Somerville

Nursing Education and Recruitment, Permanent Committee on

(Established by direction of 1963 House of Delegates)
Jesse McCall, M.D., *Chairman* . Newton
George E. Barbour, M.D. . . . Somerville
William P. Mulford, M.D. . Beverly
Lewis E. Savel, M.D. . South Orange
Mr. Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey League for Nurses
New Jersey State Nurses' Association
Administrators of Nursing Schools
Advisors (2) from State Department of Education

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)
Harvey P. Einhorn, M.D. . . . . South Orange

OCHAMPUS (Office for the Civilian Health And Medical Program of the Uniformed Services)

(1) Fiscal Agent
(Designated upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey
(2) Special Committee on
(Established by MSNJ — 9/9/56)
Nicholas A. Bertha, M.D., *Chairman* . . Wharton
George E. Barbour, M.D. . . . . Somerville
Thomas C. DeCecio, M.D. . . . . Cliffside Park
John F. Kustrup, M.D. . . . . Trenton

Osteopaths to MSNJ Membership, Committee on Admission of

(Established at request of 1969 House of Delegates)
Elbert H. Pogue, M.D., *Chairman* . . . . . Elizabeth
Louis F. Albright, M.D. . . . . Spring Lake
A. Guy Campo, M.D. . . . . Westville
John J. Crosby, Jr., M.D. . . . . Jersey City
Raymond A. McCormack, Jr., M.D. . . Trenton

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)
Joseph R. Jehl, M.D. . . . . Clifton

Pension Plan, Special Committee on

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)
Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* . . . Cliffside Park
Nicholas A. Bertha, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* . . . . . Wharton
Samuel J. Lloyd, M.D., *Treasurer* . . . . Trenton

Public Health Association, New Jersey

(1) Membership authorized by Board — 11/15/59
Joseph R. Jehl, M.D. (Delegate) . . . . . Clifton
Mr. Richard I. Nevin (Alternate) . . . . Trenton
(2) Animal (Medical) Research
(Liaison representative requested by Association — 4/17/66)
Edwin H. Albano, M.D. . . . . East Orange
(3) Medical Care Committee
(Association requested physician to serve as chairman of its Medical Care Committee — 2/24/65)
John J. Bedrick, M.D. . . . . Bayonne

Public Health Council, State Department of Health

(Nominations for appointment by Governor . . . requested — 9/20/64)
Henry L. Drezner, M.D. . . . . Trenton

Quackery, Committee on

(Established at the request of the AMA — 11/15/64)
Thomas C. DeCecio, M.D., *Chairman* Cliffside Park
Henry J. Mineur, M.D. . . . . Cranford
Charles B. Norton, M.D. . . . . Woodstown

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested — 7/18/65)
Bernard M. Schnur, M.D. . . . . Trenton

Radiation Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)
Frank Schell, M.D. . . . . Paterson
John Thompson, M.D. . . . . Caldwell

Regional Planning Council, Philadelphia Medical Library Committee

(Appointment of representative requested by Library Committee 8/20/67)
Sherman Garrison, M.D. . . . . Bridgeton

Rehabilitation Commission, New Jersey State

(Liaison requested by MSNJ's Committee on Rehabilitation — 5/65)
Carl A. Maxwell, M.D. . . . . Phillipsburg

Safety Council, New Jersey State

(Provided in Council Bylaws)
Nicholas A. Bertha, M.D., *President* . . Wharton
Joseph A. Lepree, M.D., *President's Representative* . . . . . Elizabeth

Selective Service System, New Jersey Chairman of Advisory Committee to

(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)
Jesse McCall, M.D. . . . . Newton

Statutes Related to the Practice of Medicine and Surgery in New Jersey, Committee to Review
(Established by MSNJ to implement substitute resolutions 7 & 8, 1967 House)
Nicholas A. Bertha, M.D., *Chairman* ..... Wharton
Thomas C. DeCecio, M.D. ..... Cliffside Park
Samuel J. Lloyd, M.D. ..... Trenton
Mr. Richard I. Nevin, *Executive Director* .... Trenton
Mr. E. Powers Mincher, *Legal Counsel* ... Pennington
Mr. Vincent A. Maressa, *Executive Assistant* .. Trenton

Tuberculosis Council, New Jersey State
(Appointment of representative to council requested by Commissioner of Health — 2/19/61)
Rudoph G. Matflerd, M.D. ..... New Brunswick

Welfare Council, New Jersey
(Representative to plan meetings for annual conference on social welfare requested by council — 5/13/66)
John J. Bedrick, M.D. ..... Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of
(Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D. ..... Clifton

PRESIDENTS AND SECRETARIES OF COMPONENT MEDICAL SOCIETIES

Atlantic
Donald Davidson, M.D., *President* ..... Atlantic City
William G. Wosnack, Jr., M.D., *Secretary* .Atlantic City
Mrs. Jo Ann Raco, *Exec. Secretary* ..... Margate City

Bergen
Richard B. Berlin, M.D., *President* ..... Hackensack
Frank R. Begen, M.D., *Secretary* ..... Hackensack
Mr. Allen W. Fincke, *Exec. Secretary* .... Hackensack

Burlington
David Flinker, M.D., *President* ..... Medford
Martin B. Bauman, M.D., *Secretary* ..... Medford
Mrs. Ruth E. Bunning, *Exec. Secretary* ..... Medford

Camden
E. Spencer Paisley, M.D., *President* .. Haddon Heights
Robert S. Gamon, M.D., *Secretary* ..... Cherry Hill
Mrs. Florence J. Yeager, *Exec. Secretary* .Merchantville

Cape May
Robert J. Sorensen, M.D., *President* ..... Rio Grande
Joseph M. Fitzgerald, M.D., *Secretary* ..... Cape May

Cumberland
Paul Sher, M.D., *President* ..... Millville
Frank J. T. Aitken, M.D., *Secretary* ..... Bridgeton

Essex
Myer J. Kern, M.D., *President* ..... Irvington
Richard R. Chamberlain, M.D., *Secretary* . Maplewood
Mr. Arthur R. Ellenberger, *Exec. Secretary* East Orange

Gloucester
Dominic F. Carlino, M.D., *President* ..... Woodbury
Don B. Weems, Jr., M.D., *Secretary* ..... Pitman
Mrs. Doreen Ficara, *Exec. Secretary* ..... Woodbury

Hudson
Sidney Woltz, M.D., *President* ..... Union City
Clifford B. Blasi, M.D., *Secretary* ..... Jersey City
Mrs. Julia Z. Wolf, *Exec. Secretary* ..... Jersey City

Hunterdon
Frederick Knocke, M.D., *President* ..... Readington
James R. Wiant, M.D., *Secretary* ..... Glen Gardner

Mercer
Ivan F. Bird, M.D., *President* ..... Trenton
Bernard A. Balsis, M.D., *Secretary* ..... Trenton
Mrs. Annette B. Nicholas, *Exec. Secretary* ..... Trenton

Middlesex
George T. Henderson, M.D., *President* ..... Bound Brook
Aristotle A. Christou, M.D., *Secretary* ..... Edison
Miss Carolyn M. Kidd, *Office Secretary* ..... Edison

Monmouth
Avrohm Jacobson, M.D., *President* ..... Asbury Park
Myra R. Zinke, M.D., *Secretary* ..... Holmdel
Mrs. Mary G. Gorman, *Exec. Secretary* ..... Avon

Morris
Seymour F. Kuvin, M.D., *President* ..... Livingston
Andrew G. Hudacek, M.D., *Secretary* ..... Morristown
Mrs. Irma E. Crum, *Exec. Secretary* ..... Morristown

Ocean
Irving Dunn, M.D., *President* ..... Bay Head
Joel Powers, M.D., *Secretary* ..... Toms River
Mr. John Schaefer, *Exec. Secretary* ..... Jackson

Passaic
James A. Rogers, M.D., *President* ..... Paterson
Roger C. Laauwe, M.D., *Secretary* ..... Paterson
Mrs. Katherine Cingale, *Exec. Secretary* ..... Paterson

Salem
John J. Reinhard, M.D., *President* ..... Salem
Charles E. Gilpatrick, M.D., *Secretary* ..... Carney's Point

Somerset
Harold N. Wender, M.D., *President* ..... Somerville
William S. Z. Kuh, M.D., *Secretary* ..... Somerville
Mrs. Betty Menapace, *Exec. Secretary* ..... Somerville

Sussex
Douglas Hammett, M.D., *President* ..... Sparta
Jack Caleca, M.D., *Secretary* ..... Andover

Union
Edward M. Coe, M.D., *President* ..... Elizabeth
Howard H. Lehr, M.D., *Secretary* ..... Elizabeth
Miss Mary Louise Rogers, *Exec. Secretary* ..... Elizabeth

Warren
Joseph P. Murphy, M.D., *President* ..... Phillipsburg
Ralph M. L. Buchanan, M.D., *Secretary* ..... Phillipsburg
Miss Josephine Lisinicchia, *Exec. Secretary* Phillipsburg

A New Thanatology Organization

A Foundation of Thanatology has been established. It is concerned with inquiries into and promotion of the application of knowledge to the subjects of the psychologic aspects of dying, reactions to death, loss and grief, and recovery from bereavement.

This is a non-profit organization to service the fields of psychiatry, medicine, religion, psychology, social sciences, nursing, social welfare, philosophy, and theology, as well as directly to assist the bereaved.

The Foundation of Thanatology derived initial impetus from a group of more than 100 author-contributors to a series of books, at various levels of reader sophistication, for the laity, dealing with recovery from bereavement. Also developed is a medical text for the health professions, *Loss and Grief: Psychological Management in Medical Practice,* to be published this year by the Columbia University Press. Its Board of Professional Advisors initially consisted of contributors and creative consultants responsible for these books. They have since been joined by others in many professions and disciplines who have become interested in and have offered their services to carry forward the organizational, publication, and research activities of the Foundation.

As a multidisciplinary organization, the Foundation solicits the interest of and attempts to be of service to all persons regardless of academic discipline or interests who are concerned with those subjects.

Anticipated is the development of a publication program including: *The Archives of The Foundation of Thanatology* (to commence publication this year) to be sent to members and academic libraries; publication of a scientific-professional-pastoral *Journal of Thanatology* to commence publication in 1970; publication of selected manuscripts submitted to the Foundation for this purpose; inauguration of a yearly review volume containing (in addition to original manuscripts) the Foundation transactions, selected abstracts, and book reviews.

Sponsorship of an annual symposium with subsequent publication of papers and workshop proceedings is planned. The first of these, "Psychosocial Aspects of Terminal Care," which will take place next year, will also be published in book form.

Sponsorship and direct initiation of an extensive retrospective and prospective research program in such fields as medical nursing and divinity school education, use of psychopharmacologic agents, and so on, in the area of the Foundation's concern, will be explored.

Associate Membership in The Foundation of Thanatology is open to all. Additional information concerning the Foundation will be sent upon request to the Foundation's President, Dr. Austin H. Kutscher, Columbia-Presbyterian Medical Center, 630 West 168th Street, New York City 10032.

LETTER TO THE JOURNAL

Treatment Of Infected Wounds

Dear Sir:

This is in connection with an article published in the June 1969 issue of *The Journal,* "Antibiotic For Infected Wounds."

My experience over the years is this: Using Terramycin topical powder with Polymyxin B was the most effective antibiotic for treatment of wounds, lacerations, abrasions, and dog-bites.

I. J. Wolf, M.D.

ANNOUNCEMENTS

Simplified Electrocardiography

Columbus Hospital in Newark is giving its 8th annual course in electrocardiography for the family physician. The meetings are held at 10 a.m. on Wednesdays. They begin on October 1, 1969 and run through May 13, 1970, except during Christmas week.

The AAGP gives 64 hours of credit for those who take the entire program. The meetings are held at the hospital Annex, 477 North 13th Street. The tuition is $100. This includes teaching aids, printed lecture outlines, a closing banquet, and buffet luncheon after each session.

For further details write to Joseph A. Santangelo, M.D., 539 Mt. Prospect Avenue, Newark 07104.

Management of Scoliosis

Columbia University has now made available an intensive three day course in the management of scoliosis. This will be from Thursday, October 2 through Saturday, October 4. The tuition fee is $150. For details, write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 631 West 168th Street, New York 10032.

Health Care As A Right

That "health care is a right, not a privilege" is the theme of the next annual meeting of the Tuberculosis-Respiratory Disease Association. This will be an all-day session on October 8, 1969 at the Nassau Inn in Princeton. Speakers will include Dr. Robert Cadmus, President of the New Jersey College of Medicine, and Dr. John L. Holloman, Past-President of the National Medical Association.

For more details, write to the Managing Director, New Jersey Tuberculosis Association, 2441 Route 22, Union, New Jersey 07083.

Air Pollution Emergencies

"Air Pollution Emergencies" will be the theme of a conference of the Mid-Atlantic States Section, Air Pollution Control Association, on Friday, October 17. The sessions will be held in the auditorium of the Public Service Electric and Gas Company, 70 Park Place in Newark. The program will include a review of emergency procedures in New York, New Jersey, Pennsylvania, and Delaware. Industrial representatives will present papers, as well.

Refresher In GYN-OB

During the week of November 10, 1969 Columbia University will offer a refresher course in obstetric and gynecologic pathology, which will include a survey of recent advances in the understanding of problems of the female reproductive system. For details, write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 631 West 168th Street, New York 10032.

Clinical Application Of Basic Sciences

Burlington County Memorial Hospital announces the continuation of its series on basic sciences and clinical application. The October meetings will be held on Thursdays at 3:30 p.m. in the T. J. Summey Building of the hospital. Topics to be considered are: vascular insufficiency, disorders of malabsorption, jaundice, sequelae of the use of oral contraceptives, and the role of the pastor in death. The course is acceptable by the AAGP for 1½ credits per session.

For registration and further information, please write to J. R. Wolgamot, M.D., Director of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969
September

10 **New Jersey Heart Association and New Jersey Department of Health**
Ocean County Community College
Toms River
Seminar on Stroke

11 **Burlington County Memorial Hospital**
Mount Holly
Principles of Total Intravenous Nutrition

16 **Academy of Medicine of New Jersey**
Newcomb Hospital
Vineland
Organization of Emergency Room Care

17 **Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
A Clinic and Histopathologic Survey of Gynecology

18 **Burlington County Memorial Hospital**
Mount Holly
Granulomatous and Ulcerative Colitis: Differential Diagnosis, Complications and Management

23 **Hunterdon County Medical Society**

24 **Academy of Medicine of New Jersey**
St. Elizabeth Hospital
Elizabeth
Pulmonary Problems and Inhalation Therapy

24 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Hypnosis in Medicine

25 **Academy of Medicine of New Jersey, Section on Radiology, and New Jersey Radiological Society**
Academy of Medicine of New Jersey
Bloomfield
Interesting X-rays of the Month

25 **Burlington County Memorial Hospital**
Mount Holly
The Diagnosis and Management of Some Common and Uncommon Gallbladder Conditions

26 **Academy of Medicine of New Jersey**
Newcomb Hospital
Vineland
Organization of Coronary Care Units

October

2 **Burlington County Memorial Hospital**
Mount Holly
Mesenteric Vascular Insufficiency: Diagnosis and the Approach to Treatment

7 **Academy of Medicine of New Jersey**
West Hudson Hospital
Kearny
Organization of Coronary Care Units

9 **Academy of Medicine of New Jersey**
Fair Lawn Hospital
Fair Lawn
Pulmonary Problems and Inhalation Therapy and Resuscitation

9 **Burlington County Memorial Hospital**
Mount Holly
Diseases of Intestinal Malabsorption

14 **Academy of Medicine of New Jersey Section on Dermatology and New Jersey Dermatological Society**
Elizabeth General Hospital
Elizabeth
Skin Manifestations of Regional Ileitis and Ulcerative Colitis

15 **Academy of Medicine of New Jersey**
Robert Treat Hotel
Newark
Symposium: Organ Transplants

15 **Academy of Medicine of New Jersey and American Cancer Society**
St. Elizabeth Hospital
Elizabeth
Chemotherapy of Cancer

15 **Academy of Medicine of New Jersey**
Section on Urology
Marriott Motor Inn
Saddle Brook
Urology in Viet Nam

16 **Burlington County Memorial Hospital**
Mount Holly
The Differential Diagnosis of Jaundice

16 **Academy of Medicine of New Jersey**
Passaic General Hospital
Passaic
Pulmonary Problems and Inhalation Therapy

20-24 **Newark Beth Israel Medical Center and Academy of Medicine of New Jersey**
Newark Beth Israel Medical Center
Basic Vectorelectrocardiography

23 **Burlington County Memorial Hospital**
Mount Holly
Endocrine and Physiologic Sequelae of the Oral Contraceptives

23 **Academy of Medicine of New Jersey**
John E. Runnells Hospital
Berkeley Heights
Organization of Emergency Room Care

23 **Academy of Medicine of New Jersey, Section on Radiology, and New Jersey Radiological Society**
Academy of Medicine of New Jersey
Bloomfield
Interesting X-rays of the Month

25-26 **New Jersey Heart Association and New Jersey Regional Medical Program**
Atlantic City
Seminar on Coronary Care

29 **Academy of Medicine of New Jersey**
St. Elizabeth Hospital
Elizabeth
Hypnosis in Medicine

29 **Academy of Medicine of New Jersey**
Section on Pediatrics
Workshop on Cytogenetics

30 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar: The Role of the Pastor in Death

31 **Academy of Medicine of New Jersey and American Cancer Society**
Warren Hospital
Phillipsburg
Chemotherapy of Cancer

November

3 **Academy of Medicine of New Jersey and American Cancer Society**
Atlantic City Hospital
Atlantic City
Chemotherapy of Cancer

5 **Academy of Medicine of New Jersey**
Symposium: Controversies in Medicine

6 **Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Symposium: Infectious Diseases

6 **Burlington County Memorial Hospital**
Mount Holly
Certain Gynecologic Disorders and Endocrine Management

12 **Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
A Clinical and Histopathologic Survey of Gynecology

13 **Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Morristown Memorial Hospital
Symposium: Neuroblastoma in Children

13 **Burlington County Memorial Hospital**
Mount Holly
Hematologic Problems in Pregnancy

14 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Organization of Coronary Care Units

19 **Academy of Medicine of New Jersey, Section on Radiology, and New Jersey Radiological Society**
Academy of Medicine of New Jersey
Bloomfield
Interesting X-rays of the Month

19 **New Jersey Chapter, American Academy of Pediatrics**

Holiday Inn
Kennilworth
Seminar on Pediatric Allergy

19 **New Jersey State Dental Society**
Semiannual Session

20 **Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
Hypnosis in Medicine

20 **Burlington County Memorial Hospital**
Mount Holly
Microsurgery of the Ear

25 **Hunterdon County Medical Society**

December

3 **Academy of Medicine of New Jersey**
Symposium: Shock

3 **Academy of Medicine of New Jersey**
St. Elizabeth Hospital
Elizabeth
Organization of Emergency Room Care

4 **Burlington County Memorial Hospital**
Mount Holly
Parkinsonism: Assessment of New Therapeutic Modalities

8 **Academy of Medicine of New Jersey and American Cancer Society**
Paul Kimball Hospital
Lakewood
Chemotherapy of Cancer

9 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Workhop on Resuscitation

11 **Burlington County Memorial Hospital**
Mount Holly
Common Allergic Emergencies

18 **Burlington County Memorial Hospital**
Mount Holly
Crisis Counseling

1970

January

7 **Academy of Medicine of New Jersey**
Symposium: Immunology and Radiation Protection

8 **Burlington County Memorial Hospital**
Mount Holly
Newer Anesthetic Agents

15 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Medical Management of Gastrointestinal Hemorrhage

22 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Gastrointestinal Hemorrhage

27 **Hunterdon County Medical Society**

29 **Burlington County Memorial Hospital**
Mount Holly
Indications and Techniques for Urinary Diversionary Procedures

February

5 **Burlington County Memorial Hospital**
Mount Holly
Angiographic and Echographic Diagnosis of Genito-Urinary Lesions

11 **Academy of Medicine of New Jersey**
Symposium: "Isotopes and Recent Advances in Radiologic Diagnosis"

12 **Burlington County Memorial Hospital**
Mount Holly
Management of Chronic Renal Insufficiency

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Techniques

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

12 **Academy of Medicine of New Jersey**
Symposium: Pulmonary Embolism

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

24 **Hunterdon County Medical Society**

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

April
2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

8 **Academy of Medicine of New Jersey**
Symposium: "Neurology"

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May
6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-20 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

26 **Hunterdon County Medical Society**

27 **Academy of Medicine of New Jersey**
Annual Awards Dinner

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OBITUARIES

Dr. Stephen E. Burke

One of New Jersey's senior practitioners, Stephen E. Burke, M.D., died on May 31, 1969 at the age of 84. Dr. Burke was a general practitioner of the old school who received his M.D. at Howard University Medical School in 1915. He was active in our Essex County Medical Society and was affiliated with the Beth Israel Hospital in Newark. He was one of the laureates of our Golden Merit Award in 1965.

Dr. Joseph F. Giacona

At the age of 53 Joseph F. Giacona, M.D. of Elizabeth died on July 7, 1969. Dr. Giacona was a family physician associated with the general practice service at the Elizabeth General Hospital. He earned his M.D. at the St. Louis University Medical School in 1942, and during World War II he served as a captain in the Army of the United States.

Dr. Bernard S. Kelly

Born during the presidency of Benjamin Harrison, Bernard S. Kelly, M.D. of Jersey City died on July 5, 1969 at the age of 80. Dr. Kelly was a pioneer in pediatrics in New Jersey and received his M.D. at the Medical School of Creighton University in Omaha in 1917. He was one of the earliest members of the American Academy of Pediatrics and was active in child welfare and civic affairs in the Hudson County area. Dr. Kelly retired from active practice some years ago but maintained his interest in community activities, especially those concerning children.

Dr. William F. Krone

A familiar figure around the Medical Towers in the 1930s and 1940s is gone. William F. Krone, M.D., was one of the earliest of the otolaryngologists in the Newark area. Born in 1892, he received his M.D. at Tulane in 1916. After a brief period of general practice, he did graduate work in laryngology and otology, eventually winning board certification in that specialty. He was on the staffs of the Eye and Ear Infirmary, the Beth Israel, and the Babies' Hospitals, all of Newark. He was a long-time Fellow of the American College of Ophthalmology, Otology, and Laryngology. Dr. Krone died on June 29, 1969 at the age of 77.

Dr. Pauline A. Long

One of New Jersey senior women physicians, Pauline A. Long, died on June 18, 1969 at the age of 88. She was a 1919 graduate of the Woman's Medical College of Philadelphia. After she won one of the coveted Philadelphia General Hospital internships, she went to New Brunswick and began practice there in 1921 and continued to serve the people of Middlesex County for 35 years, retiring in 1956. She was a holder of the Golden Merit Award of The Medical Society of New Jersey and was on of the staffs of both hospitals in New Brunswick.

Dr. William J. Muster

On June 22, 1969, Dr. William J. Muster died at the untimely age of 54. Dr. Muster was a graduate of New York Medical College, class of 1941, and was an obstetrician and gynecologist in the Bergen County area, affiliated with the Valley Hospital in Ridgewood. During World War II he was a captain in the medical corps of the United States Army.

Dr. Carl W. Roessel

A most promising surgical career was cut short on July 22, 1969, with the death that day of Carl W. Roessel, M.D., Director of Surgery at the Hunterdon County Medical Center, just north of Flemington. Born in Brooklyn in 1914, Dr. Roessel received his baccalaureate degree at Princeton in 1935 and his M.D. at the College of Physicians and Surgeons of Columbia University four years later. He was both a Fellow of the American College of Surgeons and a diplomate in general surgery. Dr. Roessel was a surgeon in the Army of the United States during World War II, following his internship at the Lenox Hill Hospital.

Dr. D. Thomas Russo

On August 6, 1969, a heart attack took the life of Dominic Thomas Russo, M.D., of Raritan, a member of our Somerset County Medical Society. Born in 1910, Dr. Russo was graduated from the University of Washington Medical School in St. Louis.

For more than twenty years Dr. Russo was physician for the Bridgewater-Raritan School District. Long active in civic affairs, he was also county medical examiner for Somerset County for two decades. Dr. Russo was a general practitioner with offices in the town of Raritan.

Dr. Mario E. Sciorsci

Announcement has been made of the death on June 28, 1969 of Mario E. Sciorsci, M.D. of Hoboken. Dr. Sciorsci was a general practitioner who was affiliated with nearly all the hospitals in Hudson County. He was a graduate of the New York College of Medicine, class of 1943, and was only 54 years old at the time of his death.

Dr. Milton B. Sloane

A graduate of the Jefferson Medical College, class of 1936, Dr. Milton B. Sloane of Englewood died on June 10, 1969 at the age of 59. Dr. Sloane was a diplomate of the American Board of Dermatology. He was director of the department of dermatology at the Bergen Pines Hospital in Paramus, and was chief of that service at the Englewood Hospital.

Dr. Charles T. Steffens

Dr. Charles T. Steffens, a Fellow of the American College of Surgeons, died on June 12, 1969. Dr. Steffens was a well-known Union County surgeon and was affiliated with the Muhlenberg Hospital in Plainfield. He was a member of the New Jersey Society of Surgeons, and was a 1926 graduate of the Medical School of Boston University.

Dr. Thomas S. Thomas

One of Morris County's senior members, Thomas Stephen Thomas, M.D., died on July 21, 1969 at the age of 77. Dr. Thomas was a member of the class of 1920 at Columbia University's College of Physicians and Surgeons. He began a practice in Morris County and became increasingly skilled in surgery, eventually becoming a Fellow of the American College of Surgeons. Dr. Thomas was on the staff of the Morristown Memorial Hospital and retired in 1963.

BOOK REVIEWS

Surgery of the Adrenal Glands. Edited by Lawrence O'Neal, M.D. With eight contributors. St. Louis, 1968, Mosby. Pp 295. Illustrated. ($19.50)

In this fine book, a group of authorities discuss the adrenal glands from the viewpoint of developmental anatomy, physiologic controls, and basic mechanisms producing diseases caused by the adrenals. The biosynthesis of the adrenocortical hormones is explained and diagramed.

There are full chapters discussing Cushing's Syndrome, virilizing and feminizing states, aldosteronism, pheochromocytoma, and sympathetic tumors of the adrenals. One chapter is devoted to roentgenology of the adrenal glands.

Pre- and postoperative management and anesthesia control are discussed. The operative technic of adrenalectomy, with a review of the most desired approaches, is explained in detail. There is a good review of adrenalectomy for palliation in breast cancer.

In recent years, there has been an increase in adrenal tumor diagnosis and surgery in community hospitals. From the records of one surgeon in our own four hundred bed hospital, five adrenal tumors were removed during the past six years.

For the surgeon, this is an excellent review text and reference. The book is well indexed, has many illustrations, and has pages giving normal laboratory values as well as substances interfering with hormone determinations. The book revives your diagnostic acumen and brings you up to date on a lively subject.

GEORGE F. COWLING, M.D.

Practical Psychiatry for the Internist. Douglas Goldman, M.D.; George Ulett, M.D. St. Louis, 1968, Mosby. Pp. 168. ($9.85)

Psychiatry has finally escaped from the walls, literal or figurative, which used to surround mental hospitals. Here is a book which views the prescription of tranquilizers and mood stimulants as an effort to control the rather complicated and abnormal physiology of certain human beings — calling for an expertise far beyond the primitive concept of the psychiatrist, like the psychologist or social worker, as a manipulator of ideas, unconscious emotions, and community resources. The authors do not short-change psychotherapy — but they present it in jargon-free English. There is no neatly labeled anal personality, dominant superego, or castrating mother in the book. (There really are, of course, but Goldman and Ulett don't frighten the reader by labeling them that way.) The basic nomenclature of psychiatry gets a once-over-lightly which is fair enough in a book with this focus. This is, in general, a useful text for physicians whose prime concern is not psychiatry. The title is, perhaps, unfortunate, since the book should be helpful to laryngologists and proctologic surgeons as well as internists. And, come to think of it, it wouldn't hurt the psychiatrist any either. HENRY A. DAVIDSON, M.D.

Modern Treatment (Vol. 5, #5): Treatment of Common Allergic Problems. Roy Patterson, M.D., Editor; **Rehabilitation,** Daniel J. Feldman, M.D., Editor. New York, 1968. Hoeber Medical Division, Harper and Row. Pp. 300 ($16 per year, by subscription).

A few years ago, a surgeon friend of mine was giving a routine injection to a patient with varicose veins. Suddenly, the woman went into anaphylactic shock. He knew you gave Adrenalin® but how much? — and what else should he do? If he had read this excellent book on Modern Treatment of Common Allergic Problems, he would not have lost control of his sphincters.

All sorts of things which physicians ask allergists are answered thoroughly in simple language. For example, which antihistamine is the best? (There are over 50 on the market). When do I use steroids and what dose? What do I do about a patient who is allergic to a drug and must have it?

Do you sometimes wonder why a patient who is allergic to penicillin continues to have hives months after the antibiotic has been stopped? Page 810 will tell you why.

I recommend this book highly, not only to those particularly interested in allergy, but to any physician, in any specialty, who prescribes drugs or gives injections. FRANK L. ROSEN, M.D.

Medical Interviewing: A Programmed Manual. R. E. Froelich, M.D. and F. M. Bishop, Ph.D. St. Louis, 1969, Mosby. Pp. 116. ($4.75)

It seems fair to state that there is no book quite like this. It is a manual, both in terms of "how to do it" and in terms of "how to teach how to do it." The "it" is the medical interview. While the veterinary physician has to learn how to diagnose without interviewing his patient, the human physician has an added dimension: the patient-given history. Here, situations are presented and the physician or medical student is offered a choice of questions to ask or approaches to take. The editors comment on the effectiveness of the several kinds of questions asked by the doctor, or reactions to questions asked by the patient. Even the technics of silence and not-answering are discussed, as well as the meaning of subtle shifts in posture, ways of looking at the patient, and psychomotor manuevers. Medical history outlines are proposed and a multiple choice test is included in which the practitioner or student is offered alternate courses of action. This manual will be tremendously useful to those who patiently study it page by page, and who will accept the challenge of giving honest answers.

ABRAHAM LEFF, M.D.

The Formation of Urine by the Kidney. Filimon J. Ukradyha, Ph.D. Munich, Germany, 1968, Ukrainian Technical-Economic Institute. Pp. 333 (Price not stated)

This treatise is an extensive compilation of the physiology of the kidney together with many of the author's own experiments. Dialysis has added considerably to our scientific knowledge, and has become an exact diagnostic tool for studying the action of the kidney on such metabolities as uric acid and allantoin. This text reviews osmotic diuresis, the effect of temperature on renal function and the mechanism for competitive excretion of various substances. One section covers the comparative biology of excretion of the members of the animal kingdom beginning with the protozoa and working up through the crustacea, fish, and birds to mammals. There are final summaries in English, German, and Ukranian for those interested.

For the renal physiologist this book is a *must;* it is not a book for the clinician. ROBERT H. STACKPOLE, M.D.

What You Can Do About Cancer. Joseph C. Maroon, M.D. New York City, 1969, Doubleday. Pp. 194. ($5.95)

The author's purpose is to bridge the communication gap between the medical profession and the general public so that early medical consultation will greatly increase the chances of cure His emotional and sensational approach is, however, only partly successful. I cannot recommend the book.

Potentially curable carcinomas are discussed as to etiology, prevention, anatomy, physiology, signs and symptoms, diagnosis and treatment. The summary of each chapter is in the form of questions and answers.

The explanation of signs and symptoms of malignancy is an expansion of the American Cancer Society warning signs; however, post-coital bleeding as a symptom of cervical cancer is omitted. Referring to cervical cancer as "rare before the age 25" is not warranted. The lesion occurs in significant numbers in late teens and early twenties in certain social groups.

An inaccurate use of terminology is present throughout. Lymph nodes are referred to as "cancer-infected." The author implies that malignancy spreads by breaking through an "immunity" on the part of the host. The term "surgical-attack" leaves an undesirable impression. He understates. Thus, the discomfort of sigmoidoscopy is compared to rectal fullness prior to a howel movement. A skin biopsy is called painless. Bronchoscopy is deemed not a formidable procedure.

The final chapter warns against the evils of the medical quack. Appendices are: a summary of the malignancies discussed as well as others not covered; agencies which safe-guard the public against quacks; films available from the American Cancer Society; a bibliography of publications for the lay public and physicians

ALLAN LAZAR, M.D.



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Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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She needs time for her husband . . .
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so that she can come to terms
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when she will have additional children
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Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombaphlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditians, markedly impaired liver function, known ar suspected carcinoma of the breast, knawn ar suspected estrogen-dependent neaplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch far the earliest manifestations of thrombotic disarders (thrombophlebitis, cerebrovascular disorders, pulmonary embalism, retinal thrambosis); if present or suspected discontinue the drug immediately.

British studies reparted in April 1968[1,2] estimate there is a seven- to tenfald increase in martality and morbidity due to thromboembolic diseases in women taking oral cantraceptives. In these controlled retrospective studies, invalving 36 reparted deaths and 58 hospitalizatians due ta "idiapathic" thrombaembalism, statisticol evaluatian indicated that the differences observed between users and nan-users were highly significant. The canclusions reached in the studies ore summorized in the table below:

Camparisan af Martality and Haspitalizatian Rates Due to Thramboembolic Disease in Users and Nan-Users of Oral Cantraceptives in Britain.

Categary	Martality Rates		Haspitalization Rates (Marbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Nan-Users	0.2/100,000	0.5/100,000	5/100,000

No comporable studies ore yet ovailable in the United States. The British data, especially os they indicate the mognitude of the increased risk to the individual potient, cannot be opplied directly to wamen in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medicotion pending exomination if there is sudden partiol or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medicotion if papilledema or retinol vosculor lesions are found.

Since the sofety of Ovulen in pregnancy hos nat been demonstroted, it is recommended that pregnancy be ruled out for any potient who hos missed two consecutive periods before continuing the cantraceptive regimen. If the patient hos not adhered ta the prescribed schedule the passibility of pregnancy should be considered ot the first missed period.

A smoll froction of the hormone ogents in orol contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant connot be determined at this time.



Precautions—Pretreatment physical exomination should include special reference to the breasts and pelvic organs, and o Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended thot such tests if abnormal be repeated after the drug has been withdrawn far two months.

Pre-existing uterine fibromyomas may increase in size under the influence af progestogen-estrogen preparations.

Because these ogents may cause some degree of fluid retention, conditions which might be influenced by this factar, such os epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthraugh bleeding, and oll irregulor vaginal bleeding, consider nanfunctianal causes. Adequate diagnostic measures are indicated in undiagnased vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any passible influence of pralonged Ovulen therapy on pituitary, ovorian, adrenal, hepatic or uterine functian awaits further study.

A decrease in glucose tolerance has occurred in o significant percentage of patients on oral cantraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients shauld be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen shauld be used judiciously in young patients in whom bone growth is nat complete.

The age of the patient constitutes no obsolute limiting factor, although Ovulen therapy moy mask the onset of the climacteric.

The patholagist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral controceptives and the fallowing seriaus adverse reactions: thrombaphlebitis, pulmonary embalism.

Although available evidence is suggestive of on assaciation, such o relatianship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovasculor accidents, neuro-ocular lesians, e.g., retinal thrombosis ond aptic neuritis.

The fallawing adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptams (such as abdaminal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melosma, breast chonges (tenderness, enlargement, secretion), change in weight, chonges in cervicol erosion ond cervical secretians, suppression of loctotion when given immediately post portum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuols, mental depression.

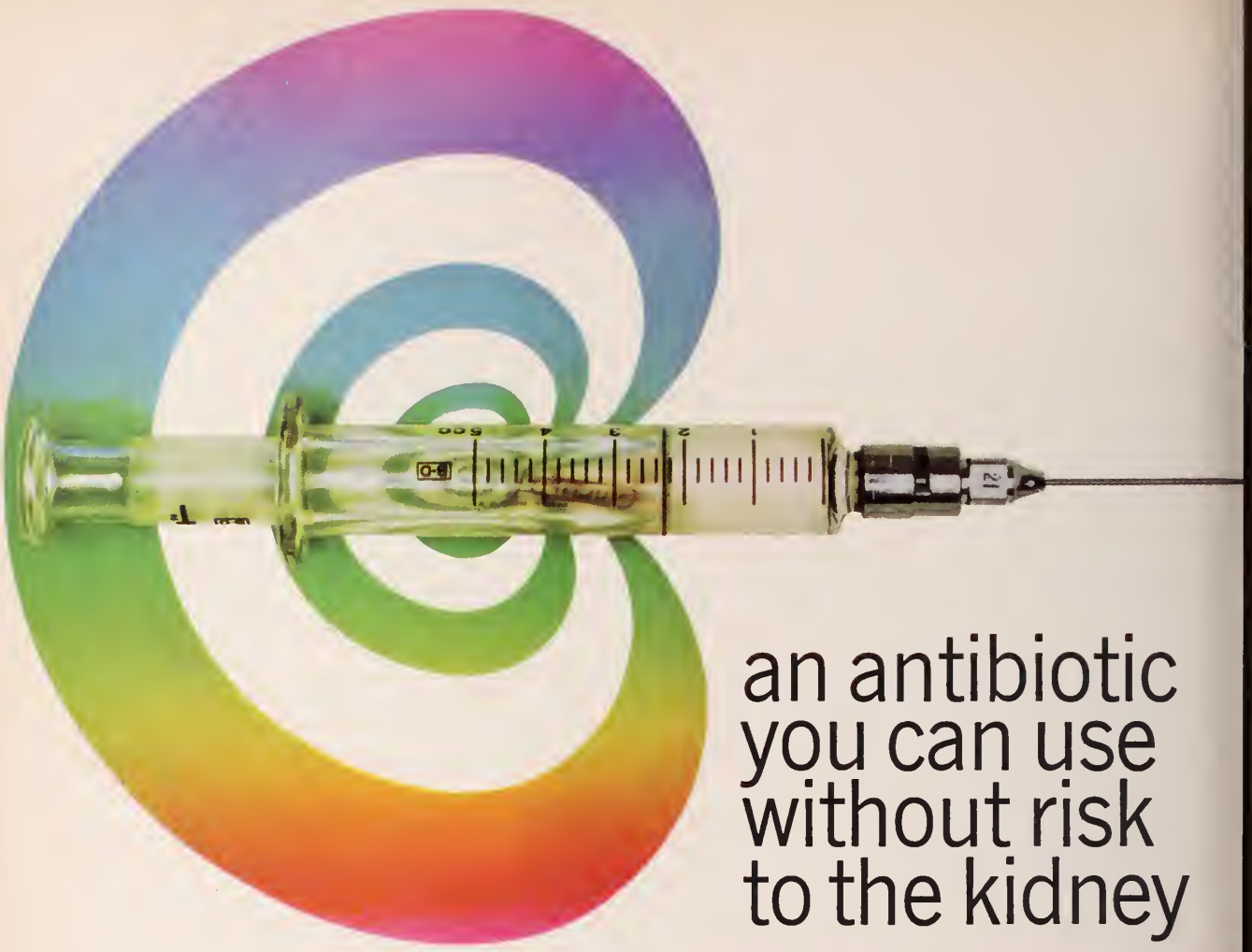
Although the following odverse reoctions hove been reported in users of orol controceptives, on ossociotion hos been neither confirmed nor refuted: onovulation post treotment, premenstruol-like syndrome, changes in libido, chonges in oppetite, cystitis-like syndrome, heodoche, nervousness, dizziness, fatigue, backache, hirsutism, loss of scolp hoir, erythemo multiforme and nodosum, hemorrhagic eruption, itching. The following loboratory results moy be oltered by orol contraceptives: hepatic function: increased sulfobromophthalein ond other tests; coagulotion tests: increose in prothrombin, Foctors VII, VIII, IX ond X; thyroid function: increose in PBI and butonol extractable protein bound iodine, and decreose in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE



an antibiotic you can use without risk to the kidney

Polycillin-N

(sodium ampicillin)

the penicillin you use like broad-spectrum antibiot

PRESCRIBING INFORMATION. 11—1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tabl

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according infection site and offending organisms). Children—50- mg./Kg./day in 3 to 4 divided doses (depending on infec site and offending organisms). Bacterial meningitis—150- mg./Kg./day in 6 to 8 divided doses. Children weighing m than 20 Kg. should be given an adult dose when prescrib orally. In parenteral administration, children weighing m than 40 Kg. should be given an adult dose. Beta-hemol streptococcal infections should be treated for at least 10 d

Supplied: Capsules—250 mg. in bottles of 24 and 100. 5 mg. in bottles of 16 and 100. For Oral Suspension—125 m 5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in and 150 ml. bottles. Chewable Tablets—125 mg. in bottles 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 m 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 bottles.

A.H.F.S. Category 8:12

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

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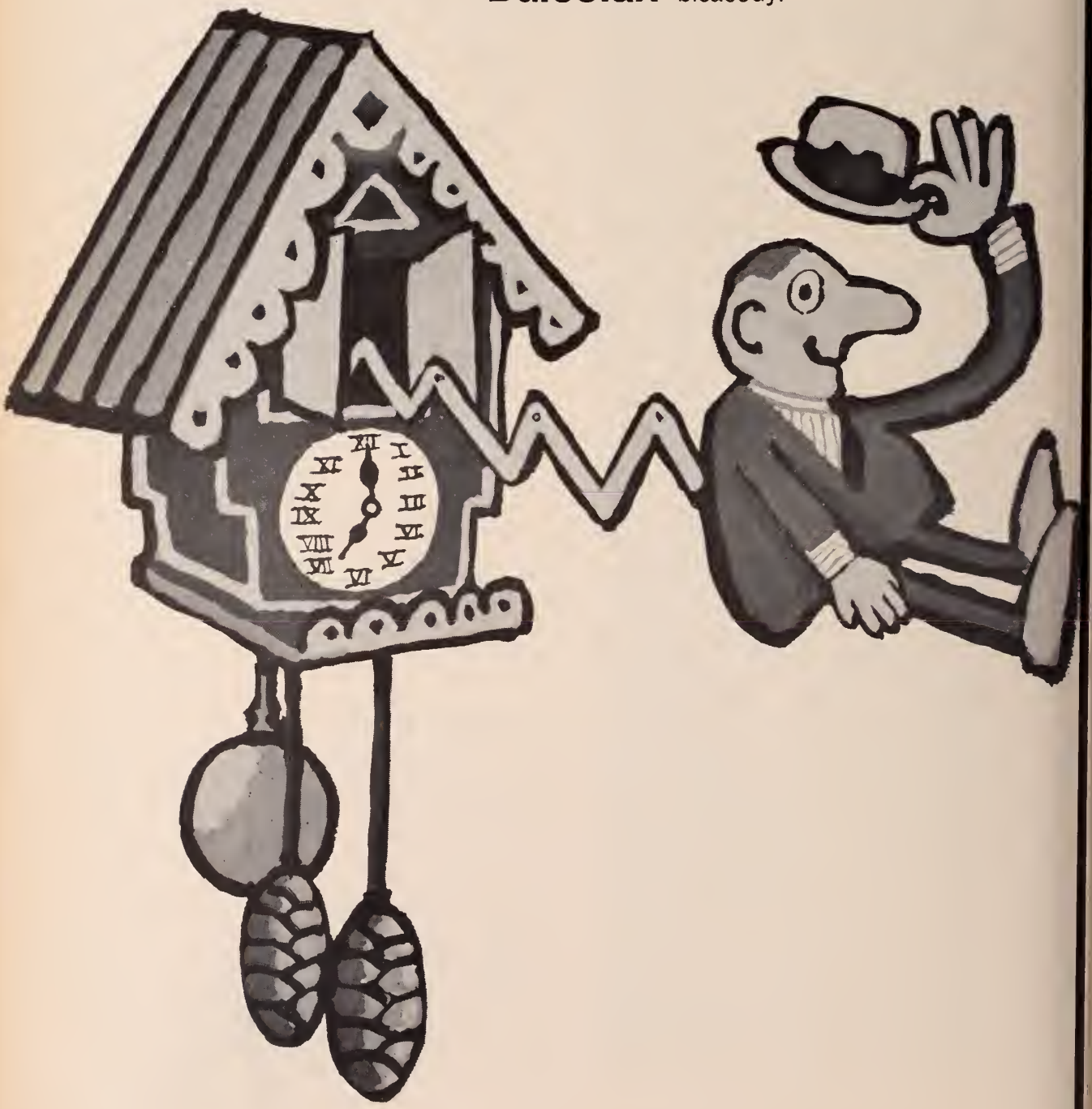
Dulcolax®...so predictable you can almost set patients by i

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

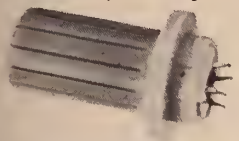
Dulcolax® bisacodyl



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TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
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because relief means so much to your G.U. patient



There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug" — but a *useful* one.

URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination. Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

URISED is safe . . . especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

URISED®

Each blue-coated tablet contains active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

Stocked Nationally Through All Service Wholesale Druggists

CONAL PHARMACEUTICALS, INC
CHICAGO, ILLINOIS 60640
MANUFACTURERS OF URICEUTICAL® SPECIALTIES



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There are medals for heroism. Valor. Bravery. And for distinguished service.

But there are no medals for loneliness.

That's why the USO is there.

It's a nice, clean, well-lighted place that our 3½ million young servicemen and women around the world need. And the USO is everywhere. From Alaska to the jungles. From big posts to the boondocks.

Sometimes it's just a warm place where people can meet, relax, write letters or tape-record letters home.

Sometimes it's help for a young family looking for a place to live. A touring show and a few laughs. Tickets to this or that. Most of all, it's people who are concerned.

But the USO needs your help. It gets no government funds. It depends entirely on your gifts to the United Fund, Community Chest or local US campaign.

Remember, that can be a lone world out there. So we're asking. An hoping.

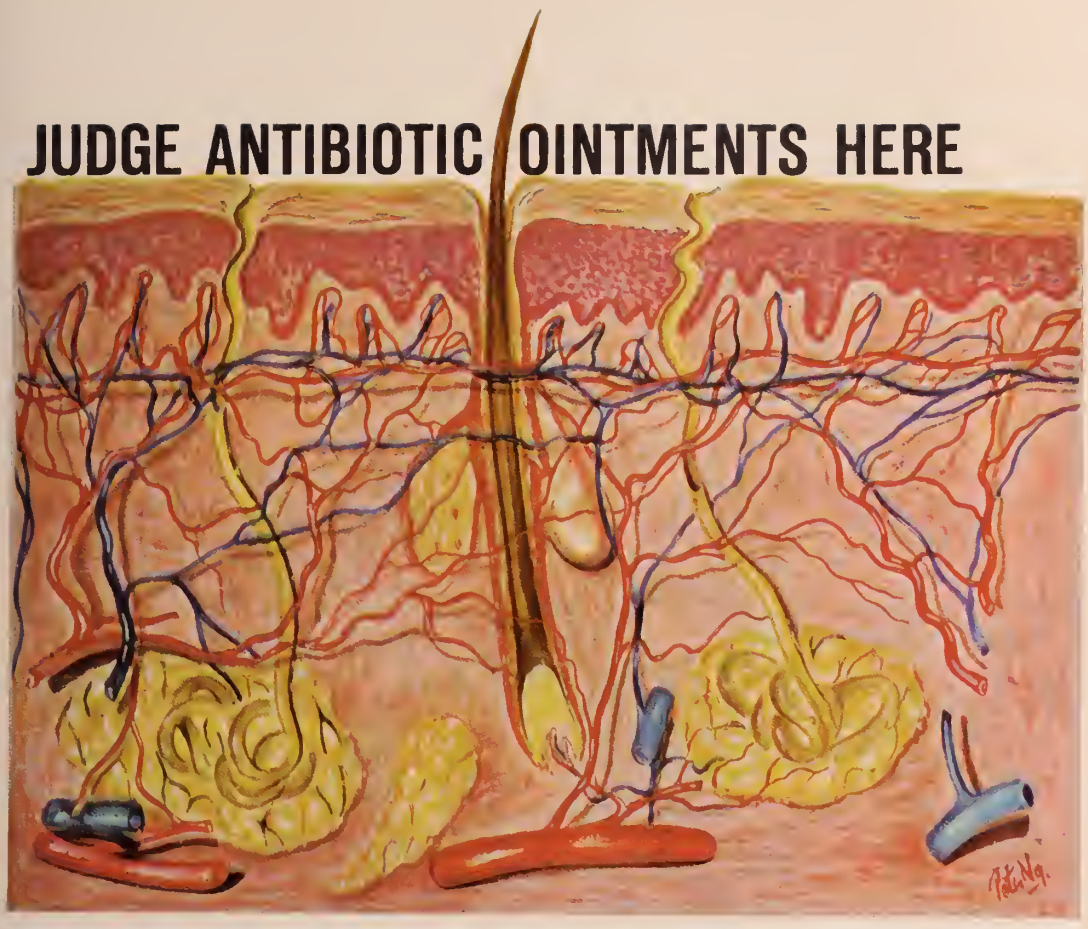
Please give. Our servicemen give more.

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

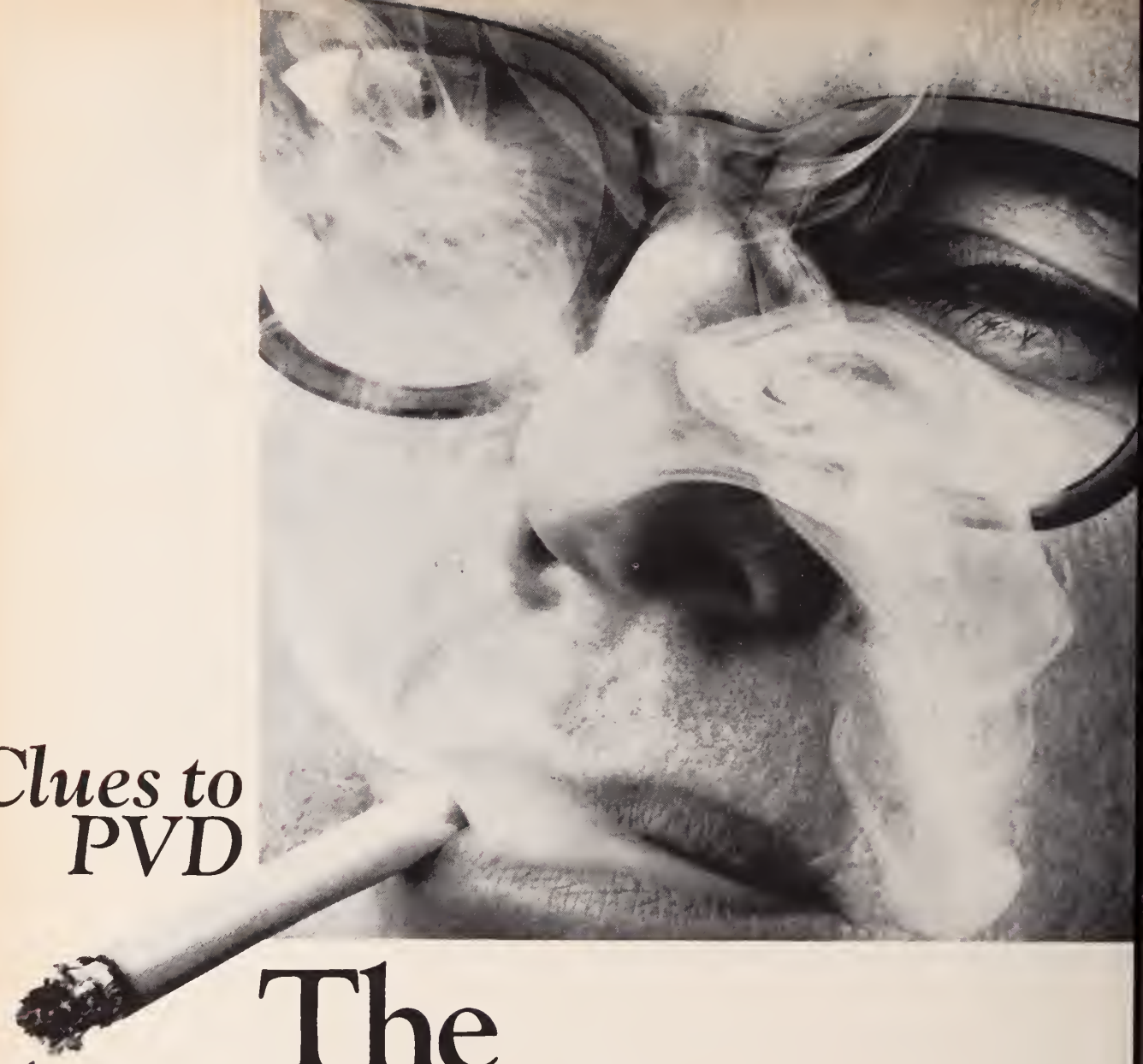
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

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POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.



Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general these cases were characterized by excessive consumption of the drug for its central stimulant effect and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions. Dryness or unpleasant taste in the mouth urticaria, overstimulation insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage. One 25 mg tablet b.i.d or t.i.d. Or one 75 mg. Endurets tablet a day. taken by midmorning
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration. in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B R3-46-560-B

Under license from
Boehringer
Ingelheim G m.b H

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502





They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

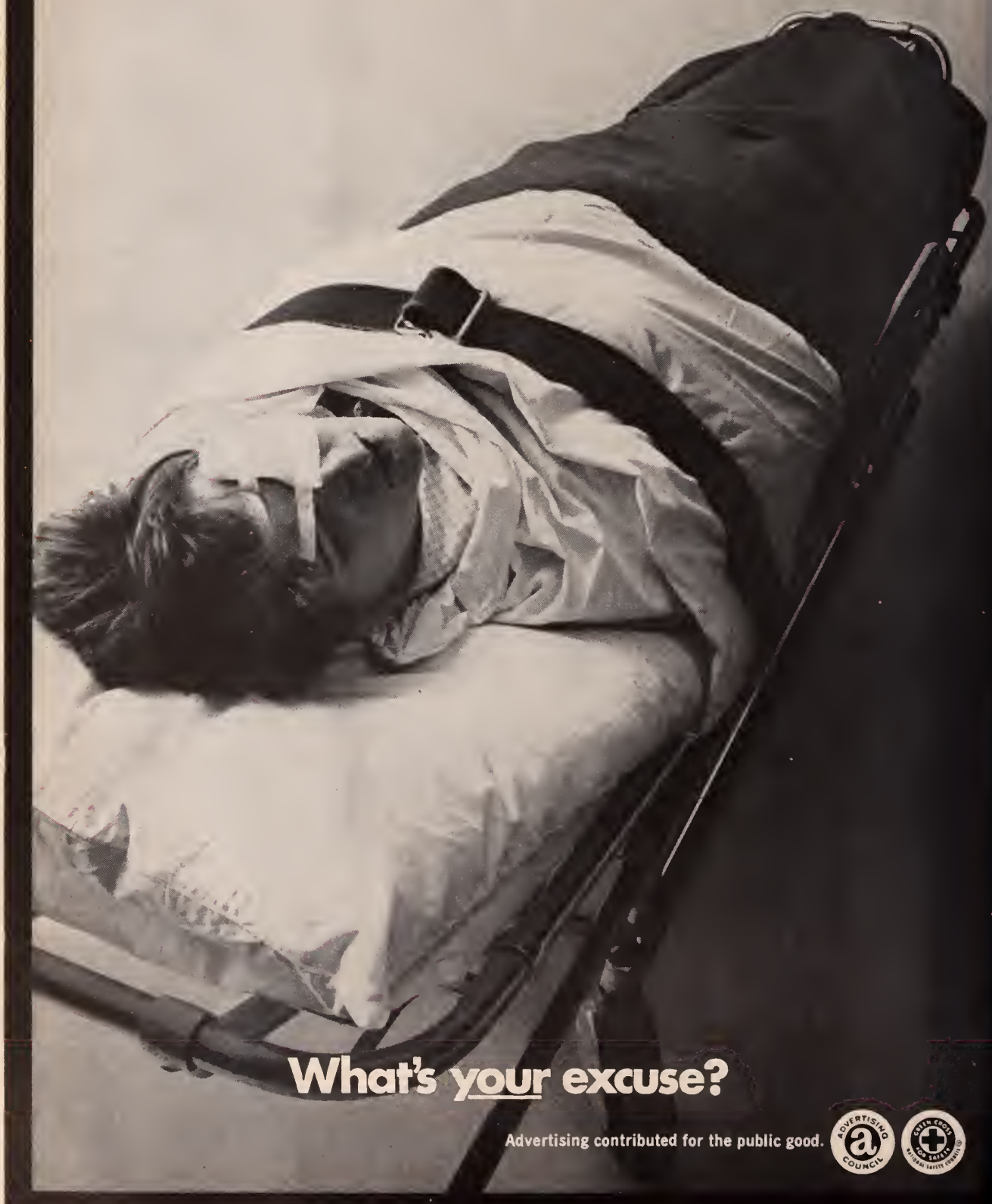
A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

Geigy

Barbara Putnam said safety belts made her feel strapped in.



What's your excuse?

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USE YOUR SAFETY BELTS

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1.SUMMARY	
ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"*Sexuol impotence treotment with methyl testosterone – thyroid (ANDROID) a double blind study*" – *Montesono, Evongelista: Clinical Medicine, April 1966.*

CONTRAINOICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg
Ethinyl Estradiol	0.02 mg
Thyroid Ext. (1/6 gr.)	10 mg
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg.

INOICATIONS Advantage is taken of the anabolic action of ANDROID without its virilizing effect Estrogen balances the androgen—only steroid effect remains Geriatrics, post-operative and debilitating disease, osteoporosis. **OOSE.** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIOE EFFECTS**· In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA INOICATIONS**. See Android Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

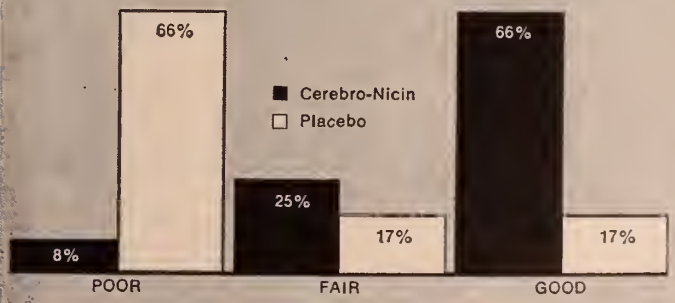
For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient. R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS. There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

STATE OF NEW JERSEY—With 30 institutions throughout the State offers excellent opportunities for physicians seeking relocation. Particularly Generalists, Internists and Pediatricians. Salaries, $14,-000 to $24,000 for State licensed physicians depending on qualifications and the type of position. 35 hour work week; 1½ annual salary in paid life insurance; retirement benefits; living accommodations at low cost in some institutions; paid annual vacation; sick leave; and and medical benefits. Modern well equipped medical facilities with affiliations and consultation services throughout system. Opportunities for limited private practice if desired. Further info write:

Bureau of Personnel Services and Employee Relations,
Department of Institutions and Agencies,
135 West Hanover Street, Trenton, New Jersey 08625.



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Infarmatian—Campasitian: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Cantraindicatians:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautians/Adverse Reactians:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating atrophic vaginitis complicated by infection... **is as easy as AVC/Dienestrol**

Dienestrol helps restore estrogen-deficient vaginal mucosa.
It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

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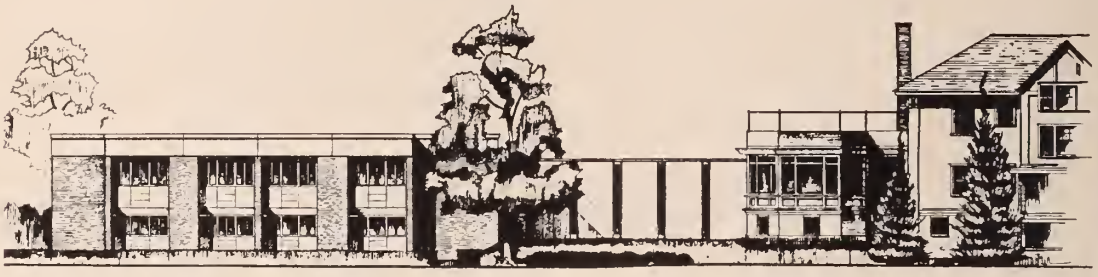
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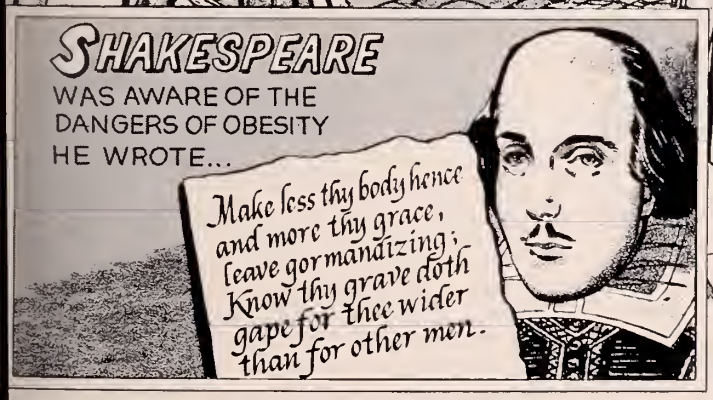
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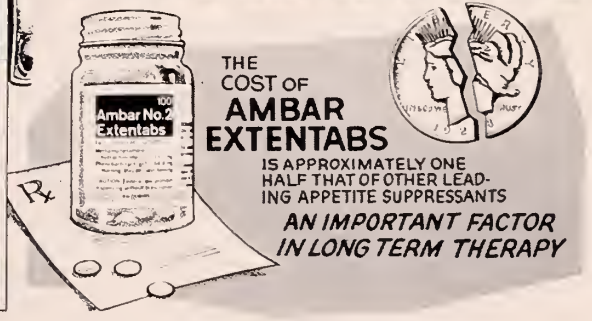


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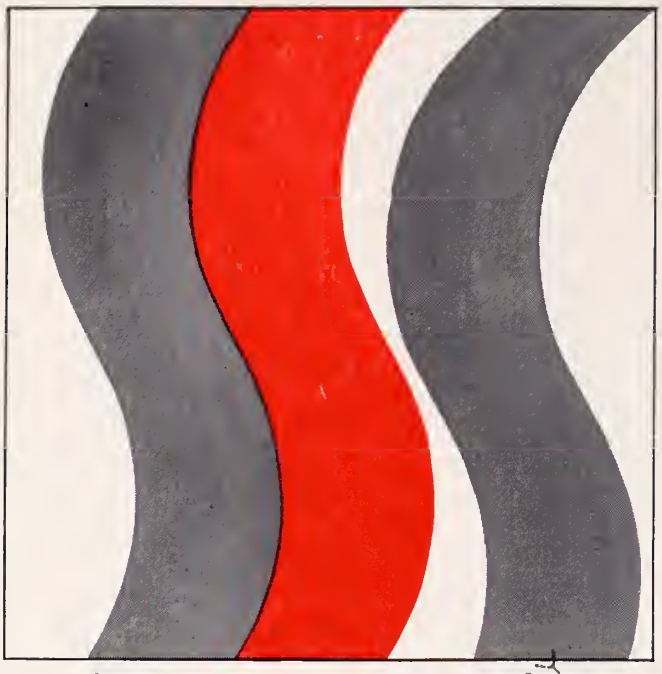
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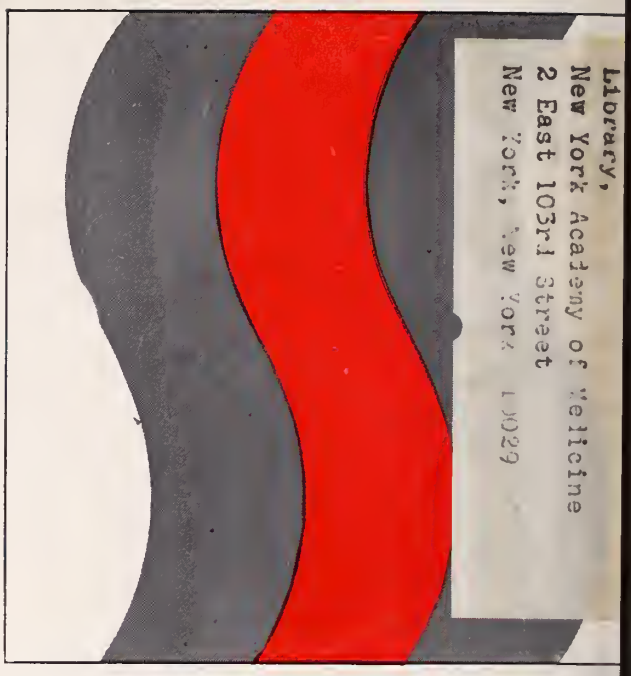
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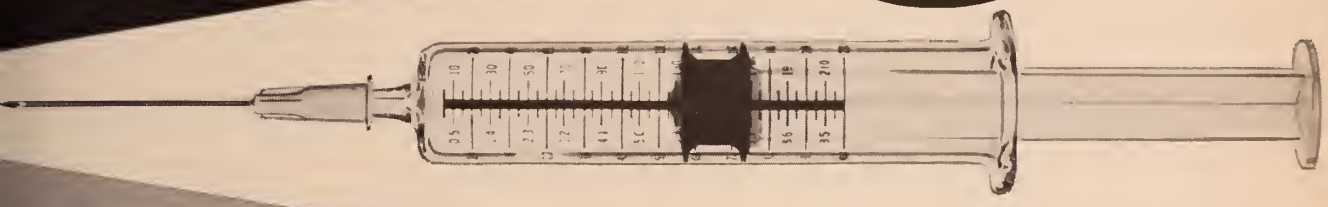
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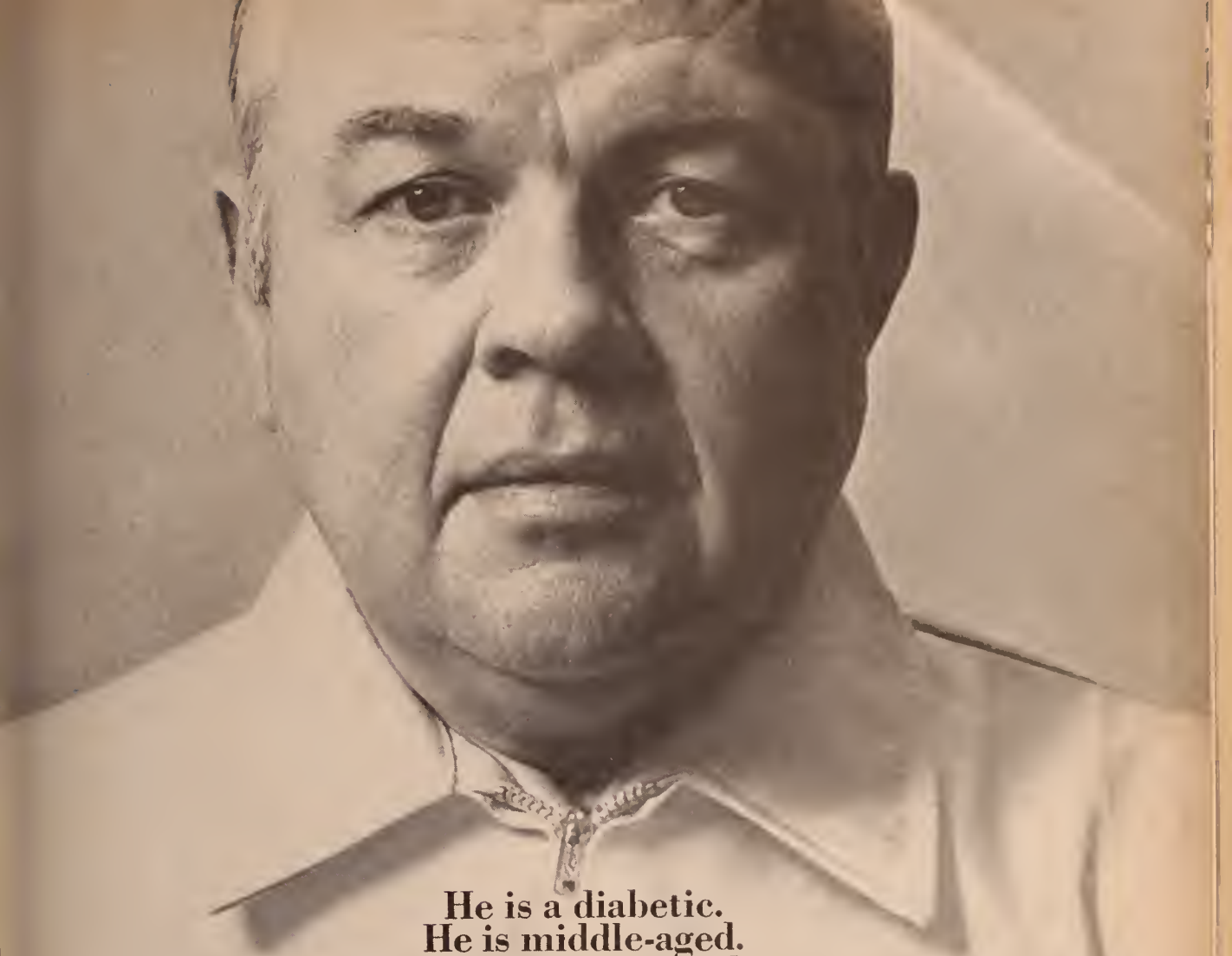
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York



In Cervicitis

Help the healing process with StomAseptine® douching

Helps flush away exudates, maintain internal cleanliness, reduce odor...reassures the patient

StomAseptine douching is a valuable adjunct to cervicitis therapy. These gentle, non-irritating internal irrigations help maintain a clear field by washing away pus and secretions...relieve itching and burning...reduce malodor...and offer the patient a refreshing, reassuring procedure that can help speed the healing process.



Write for new booklet on patient douching instructions; space is provided for your specific recommendations. Advise quantity needed. Write: **Harcliffe Laboratories, Inc., Dept. 1004, 423 Atlantic Avenue, Brooklyn, N.Y. 11217**

STOMASEPTINE® DOUCHE POWDER

Contains: Sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—Bottles of 6 oz., 15 oz., 32 oz., Cartons of 12, 10 Gm. Packets

FIRST LADY OF THE LAND.



So noble. So majestic. And, she's got a right to be. She gives Nature's finest. Pure, whole milk.

Milk to grow on. Milk to stay strong on. Real milk, Nature's most healthful food.

You may think most people know all about milk. Unfortunately, many don't.

They don't know that milk contains all the nutrients known to be needed by humans. Essential amino acids and essential fatty acids. And, too, milk contains over 140 fatty acids, and is easily digestible.

Someone should explain milk's vital role in a balanced diet of meat, breads and cereals, fruits and vegetables and dairy foods.

We hope you will do the explaining. As a professional, people will listen to you.

We'd like to help you with the facts. We have complete materials available for you to read or let others read. They're all free.

If you have a free minute, send for them.

The Real Milk Story

Dairy Council of Northern New Jersey
172 Halsted Street, East Orange, N.J. 07019

Name _____

Position _____

Address _____

City _____

State _____ Zip _____

Pertofrane® desipramine hydrochloride

Indication. Mental depression.

Contraindications. Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning. Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions. Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g., paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions. The following have been reported. *Nervous System*: dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract*: anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin*: skin rashes (including photosensitization), perspiration and flushing sensations. *Liver*: rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements*: bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System*: orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System*: urinary frequency or retention and impotence. *Endocrine System*: occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity*: urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage. All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability. Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000.

(B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Coming out of a depression

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood . . . a restoration of psychomotor activity. Patien usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even b a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the respo

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available

It's beautiful!



DRUG ABUSE: A National Problem

Blue Shield Offers Helpful Free Booklet

Now that vacation days are over, children have returned to school and doctors are back to their normal schedules. In many instances, this includes giving time to community and civic betterment through service on Boards of Education, volunteer health organizations, associations and other public-spirited enterprises.

One of the problems of greatest concern to today's society —and the various organizations that serve it—is the use of drugs by young people. Blue Shield has concerned itself with this problem by compiling and publishing, as a public service, a booklet "Drug Abuse: the Chemical Cop-Out," dealing with all phases of the drug abuse problem such as motivation, analyses of the various drugs used, legal implications, and means of combating the problem.

The booklet has been widely hailed as providing adults with the information they need to cope with the problem. Its availability from local Blue Shield Plans has been advertised in national publications, and to date, Medical-Surgical Plan of New Jersey has filled requests for more than 6,000 copies from schools, churches, police departments, a County Narcotics Bureau, departments of health, hospitals, pharmacies, business organizations and many individuals, including a number of physicians.

We believe that any physician—and particularly those who serve with organizations that deal with young people—will find the booklet informative and helpful. We invite you to send in the coupon below for a copy to examine—and then if you wish to obtain a quantity for distribution by any group or organization, write to the Plan, and we will be happy to supply as many as you need.

Medical-Surgical Plan of New Jersey
Attention: Franklin H. Romaine, Public Relations Officer
500 Broad Street
Newark, N. J. 07101

Please send me a copy of the Blue Shield booklet "Drug Abuse: the Chemical Cop-Out."

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP CODE _____

BLUE SHIELD
MEDICAL-SURGICAL PLAN ®
OF NEW JERSEY
500 Broad Street, Newark



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriasclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

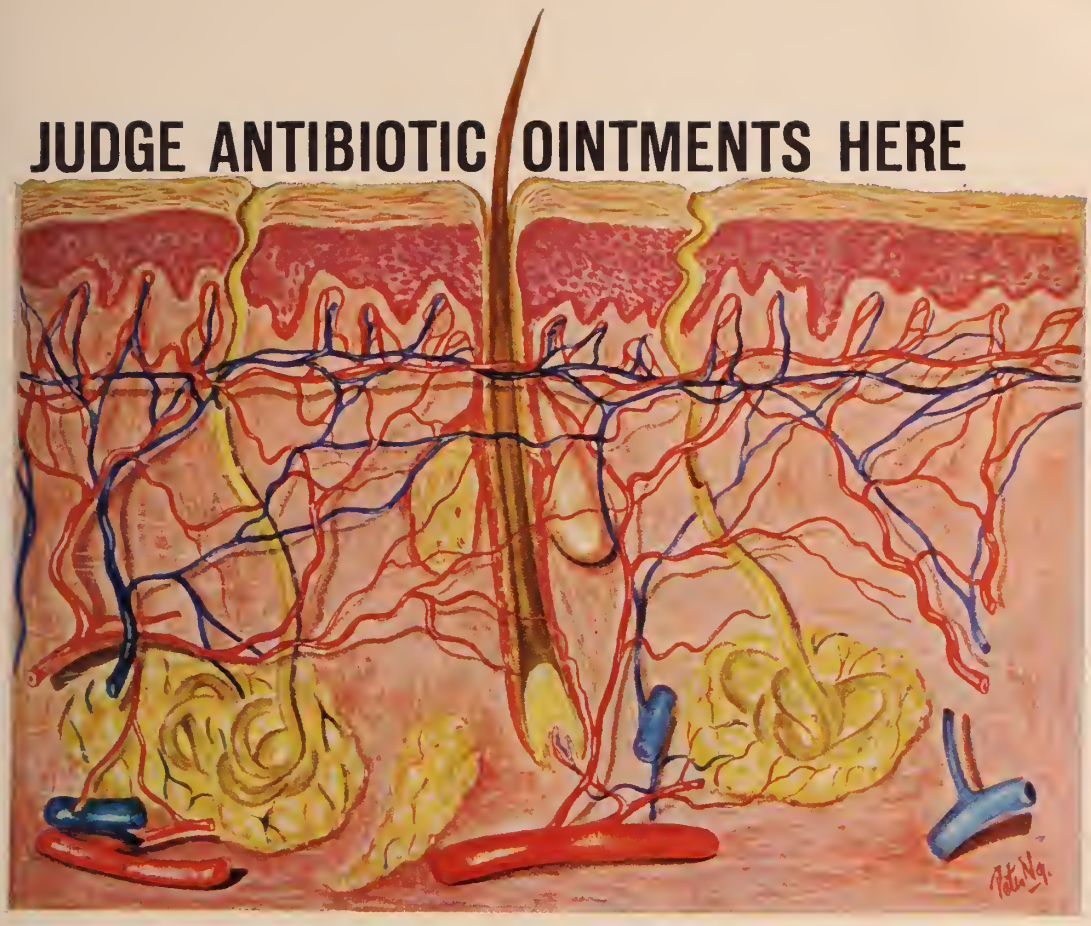
AVC CREAM (aminacrine hydrochloride 0.2%, sulfonilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK A V C

AV-919A 7/69

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

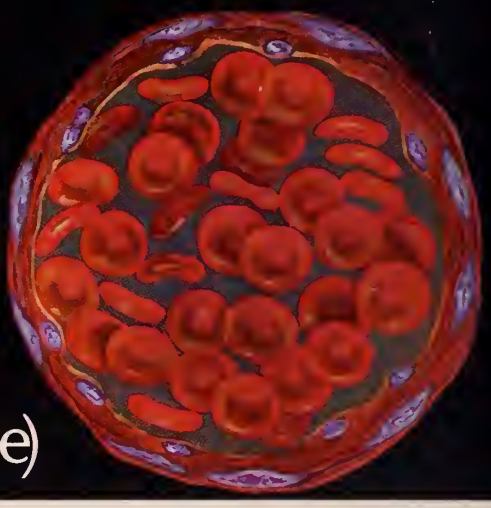
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



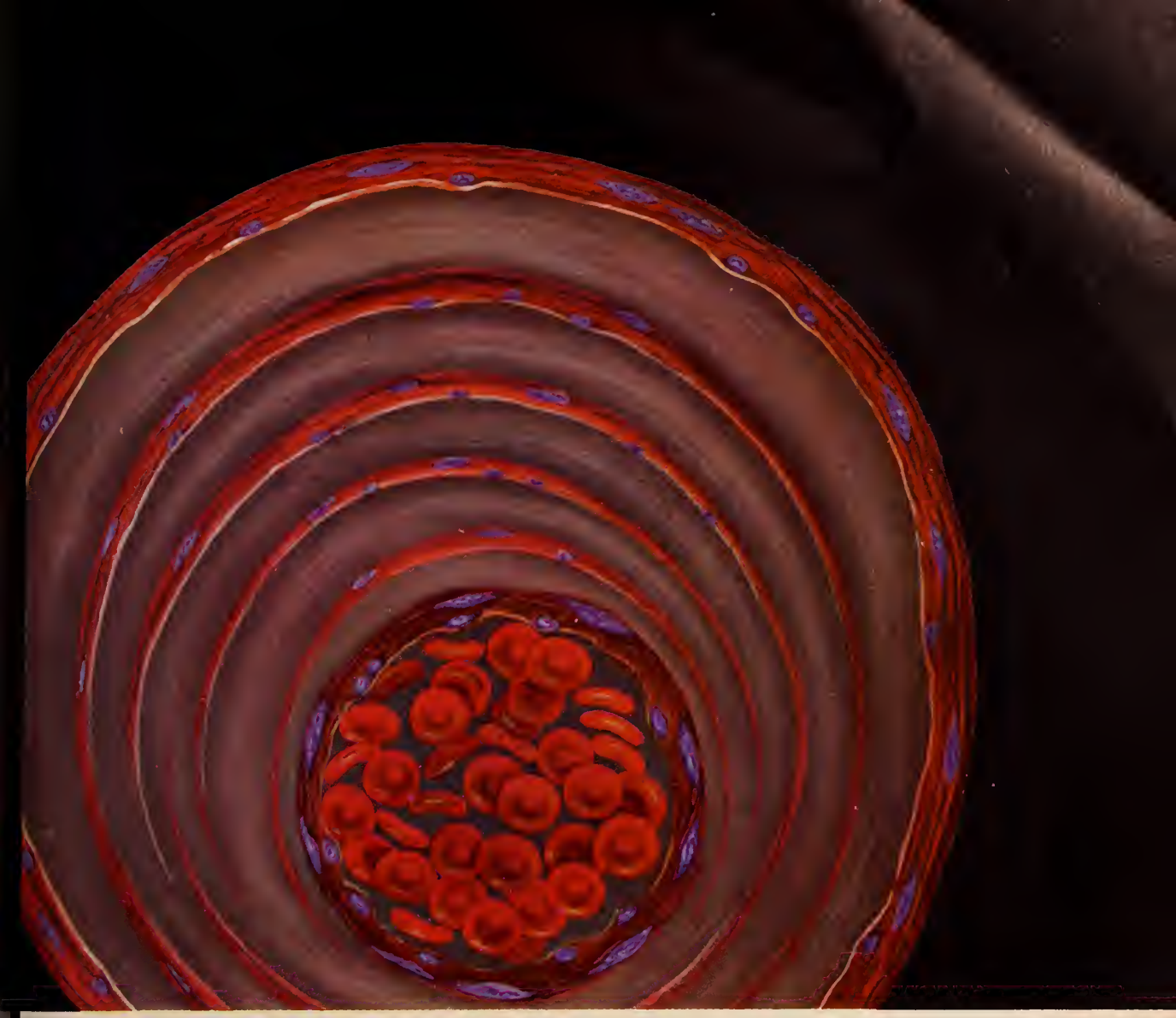
Because peripheral vasodilati is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniac seldom require discontinuation of thera

Prolonged, continuous drug release—Pr longed peripheral vasodilation is provid sustained-release Roniacol Timespan (ni alcohol tartrate) Tablets. Part of the drug comes available immediately, the remai continuously over a period of up to 12 h and dilation of constricted peripheral ve usually maintained. Thus, with a single d medication, patients can enjoy the bene increased peripheral blood flow in ische extremities for up to 12 hours.



nooth peripheral vasodilation from initial sage...extended with nple, well-tolerated, b.i.d. dosage

rolonged action of Roniacol Timespan tinyl alcohol tartrate) together with its benefits offer a therapeutically practical ure in the long-term management of heral vascular disease–advantages cially important for older patients.

e prescribing, please consult complete uct information, a summary of which ws:

ations: Conditions associated with ient circulation; e.g., peripheral vascular se, vascular spasm, varicose ulcers, bital ulcers, chilblains, Meniere's syn- e and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

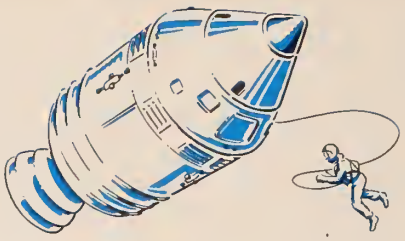
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

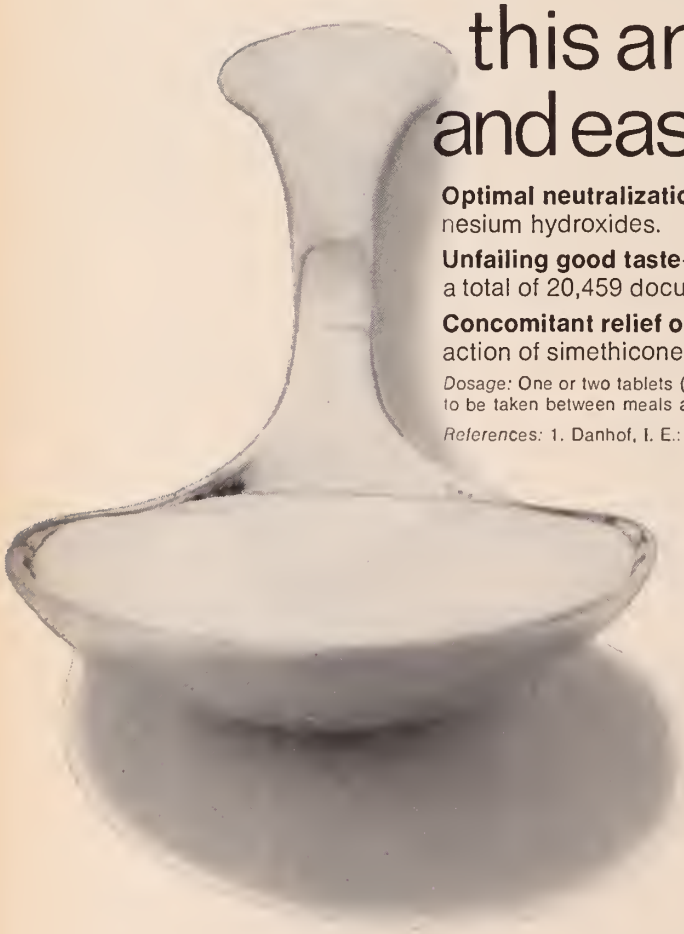
BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

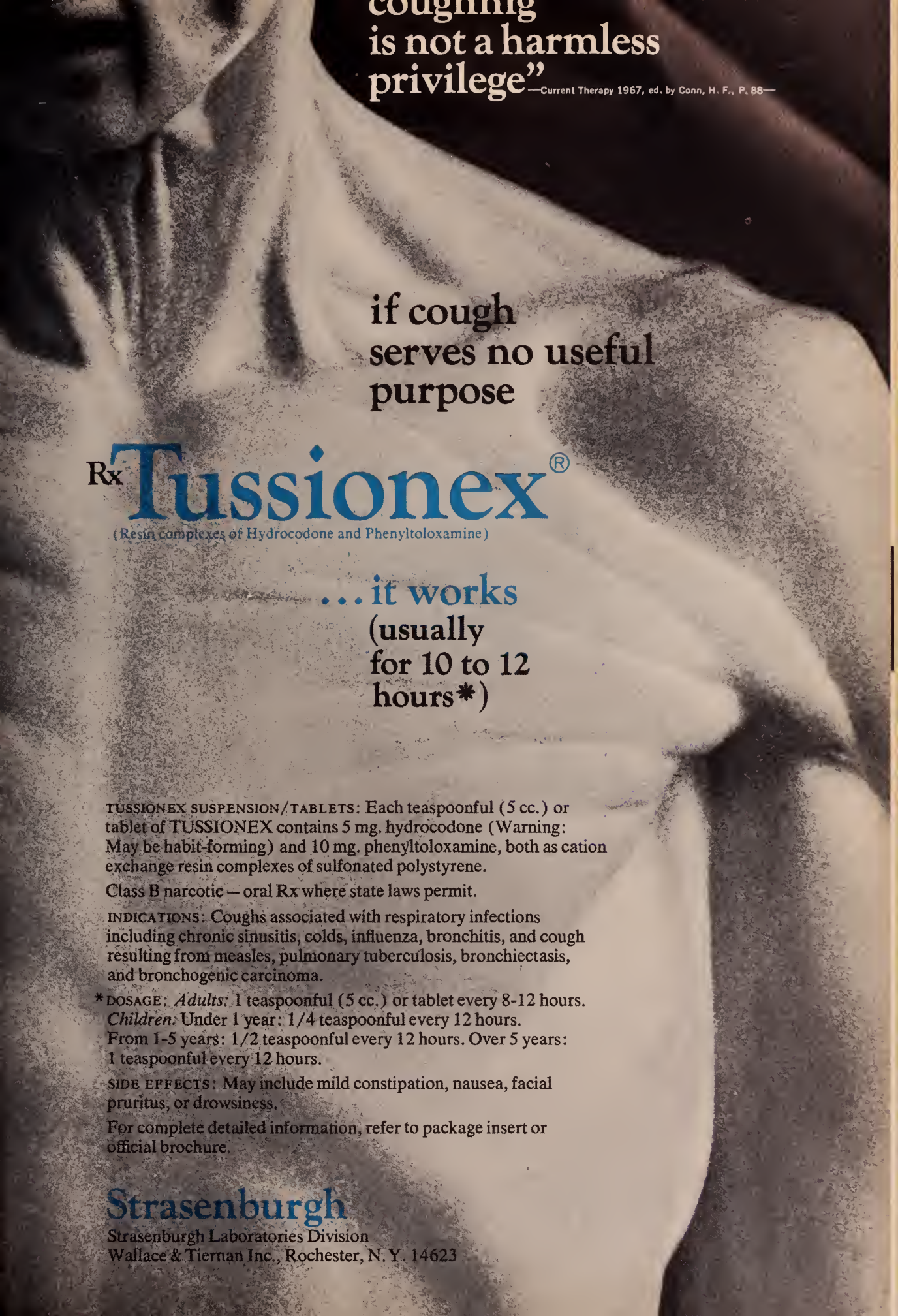
That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children.* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

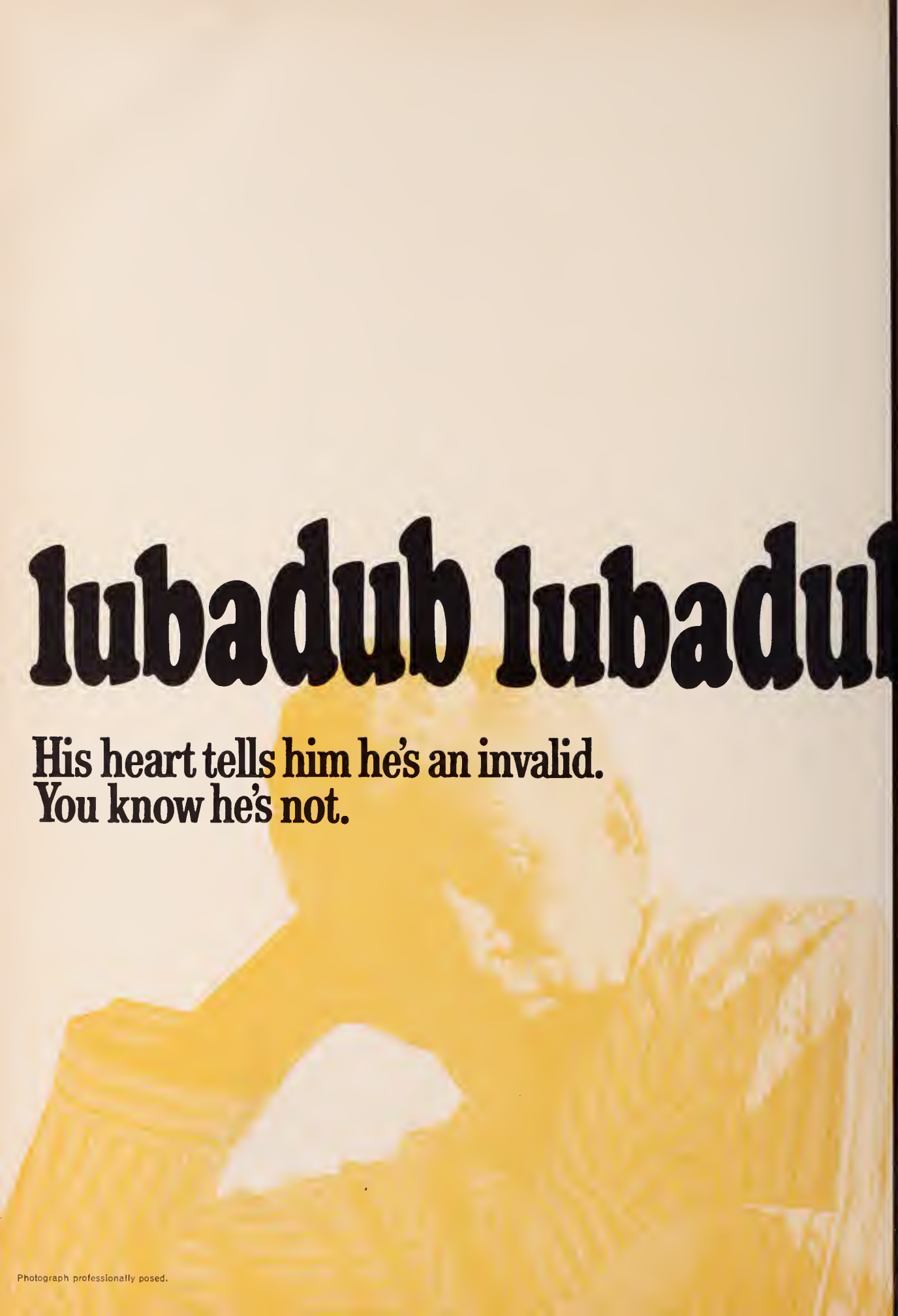
For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications ory of sensitivity to meprobamate

Important Precaution fully supervise dose and amounts prescribed, e for patients prone to overdose themselves. Ex olonged use has been reported to result in dep abituation in suscep tible persons, as alcoholics and other severe psychoneurotics. After prol e dosage, reduce dosage gradually to a ere withdrawal reactions. Abrupt discontinuanc doses has sometimes resulted in epileptiform

Warn patients of possible reduced alcoh with resultant slowing of reaction time and impair judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturba occurs; if persistent, patients should not operate veh or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

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PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

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EDITORIALS

The Mile High City

Denver is the site of the 23rd Clinical Convention of the American Medical Association. It gets its nickname from its altitude above sea level and its position at the western edge of the Great Plains near the foothills of the Rockies.

This Clinical Convention, scheduled for November 30 through December 3, is the third to be held in Denver. The first was in 1952.

Denver is unique in several ways. Its parks' system includes 13,448 acres outside the city limits in the surrounding mountain area. Even in late November and early December, the temperature can climb into the 60s. (But it also can be breezy, and snow sometimes makes a brief appearance, so it's well to bring a varied wardrobe.)

Headquarters hotel for the 23rd Clinical Convention is the Denver Hilton, towering over the downtown area and overlooking the state capitol. Scientific sessions will be in Denver's convention complex.

Denver has a population of a half-million, and there are more than a million people in its metropolitan area. Even when snow falls, roads are cleared and sanded promptly, so travel in and around Denver remains uncomplicated for those wishing to explore the sights and activities of this dramatic locale. The mountains of course are a major attraction. Colorado is the highest state in the union with an average elevation of 6,800 feet. It has 53 peaks above 14,000 feet. Denver itself has art and natural history museums, legitimate theater, a symphony orchestra, and a variety of restaurants and night clubs.

Golf and tennis are year-around sports in the area, even in winter when skiers are gliding over Colorado's powder snow only 60 miles away. The front range of the Colorado Rockies is a half-hour drive from downtown Denver, and possible trips include Pike's Peak, the Central City gold mining area, Estes Park, Air Force Academy, Rocky Mountain National Park, and other Colorado cities. Denver offers you and your family a refreshing change. And the professional program planned for the AMA's 23rd Clinical Convention is designed to give you a compact four-day graduate program.

Blue Shield Fees For Medicare and Medicaid

Our federal department of Health, Education, and Welfare has suggested that Blue Shield fee schedules might be used to reimburse physicians under Medicare and Medicaid plans. In this connection, Dr. D. W. Wilbur, AMA President, wrote to Mr. Robert Finch, Secretary of Health, Education and Welfare, and said that:

The American Medical Association is eager to make available to your office the combined experience and judgment of the nation's physicians, who are the principal providers of health care to all the people. The needs and problems of patients in all walks of life, at all income levels, come to their attention, in composite, more than a billion times a year.

It has always been the professional code of the physician that no one shall ever be denied quality health care because of his inability to pay. The present concern is how this universal care can best be provided within a viable economic system and in the face of burgeoning demands for medical manpower, services, and facilities.

The knowledge and judgment of the nation's physicians — as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others — must be enlisted in your battle against the health-care portion of the inflation problem.

Dr. Wilbur wrote to Mr. Finch following the HEW announcement that federal spending on the Medicaid-Medicare programs would be trimmed by $328 million through imposing Medicaid fee schedules based on prevailing Blue Shield rates, limiting mental illness benefits under Medicaid, and cutting down hospital overhead allowances in Medicaid and Medicare. In this connection, Dr. Wilbur explained that: "No universal pattern — no matter how many variations it may try to provide — can be imposed on the thousands of localities without wreaking havoc and probably increasing inefficiency and costs."

Concerning the imposition of Blue Shield rates as fee schedules under Medicaid, Dr. Wilbur warned that a later step "might be that of physicians in groups on salary and abandonment of the fee-for-service principle." He agreed that physicians, combatting such govenment efforts, must accept the major responsibility of keeping fees as moderate as possible.

The Drug Industry As A Public Utility

There is a kind of imaginative attractiveness about the idea at first: the pharmaceutical industry as a public utility. Those who have suggested this argue that medications, like electrical supplies or telephone services, are public necessities and the Government (with a capital G) should have something to say about the profits that the industry may make and the fees they may charge the public. It is also suggested that if the "public utility" concept is distasteful to you, the nationalization of drug distribution would be even more distasteful, and giving the industry the status of a public utility would be better than nationalization. The dreamer can go even further. At all levels (federal, county, state, and city) governments are big buyers of drugs so they have a negotiating position right here, and can compel a kind of price structure simply by open market bargaining without any legal compulsion. Then, too, there is precedent for the federal Government (through the FDA) to regulate research, testing, announcements of indications, and side effects and contra-indications so that it already has a hand on the industry's throttle.

The analogy to other public utilities fails, however, just on the matter of competition and monopoly alone. The telephone service, for instance, has to be a monopoly since it would be ridiculous and highly confusing in this age to have four different phone companies competing with each other for the right to transmit your calls. But if a phone company enjoys a monopoly, someone on the outside (the public *via* Government) has to regulate profits and prices. Our railway system would not now be in its present sad state if we hadn't for a century encouraged competition, while treating it as a public utility. The pharmaceutical industry, on the other hand, is far from a monopoly. *Physicians' Desk Reference* alone lists the products of 247 different pharmaceutical companies. The patient's pocket-book would certainly seem better protected by the free play of the American market than by establishing a monopoly. And so long as each manufacturer has to worry about "the competition," there is no justification for treating it as a public utility. And an even more telling argument is to examine the distribution of drugs in countries — Soviet Russia for instance — that do have government regulation of pricing, distribution, information-supplying, and even packaging. It is fair to state that no spectacular advance in pharmacology (or in getting a useful medication to the public) has ever been developed in a country with a nationalized pharmaceutical industry.

The triumphs of modern pharmacology are worth crowing about, as any doctor should know if he is old enough to remember when bromides were the basic tranquilizer, and elixir of iron, quinine, and strychnine the model stimulant. Some of the remarkable new drugs came from Government laboratories, some more from universities, but the great bulk of the progress came out of the pharmaceutical industry itself. And engine of all this research was the profit motive.

ORIGINAL ARTICLES

Colistin was found the most effective antibiotic for diarrhea due to Escherichia coli.

An Infantile Diarrhea Epidemic*

Comparative Response To Antibiotic Therapy

Mervin E. Fischman, M.D./Irvington; William J. Semel, M.D./Newark

In the spring and summer of 1965, Newark, New Jersey, was struck by more than 400 cases of diarrhea complicated by severe dehydration and electrolyte imbalance. Seventy-one infants and children with documented cases of acute gastroenteritis were treated at our hospital during this time. This account of our experiences at Newark Beth Israel Hospital is prompted by reports by Kessner[1] and Murray[2] of earlier but similar outbreaks.

The 48 patients with positive *E. coli* cultures are included in this report. All who had diarrhea were treated, whether infected with enteropathogenic *E. coli* (EPEC) or non-enteropathogenic *E. coli* (non-EPEC). EPEC was grown on cultures from 13 of the 48 patients. The other 35 *E. coli* strains could not be serotyped. Of the children, 82 per cent were under eighteen months and 42 per cent under six months.

All patients were placed in the diarrhea ward** where strict isolation was in force. Blood electrolyte concentrations were determined and when necessary, fluids were infused immediately. Weight, fluid intake, and urine output were recorded daily.

Stool specimens or rectal swabs were obtained daily for culturing. The frequency, amount, and character of the stools were recorded. As an added precaution, stool specimens from pediatric ward personnel were cultured weekly. (We discovered that a nurse in the newborn nursery, from which four patients came, was an EPEC carrier.) We grouped the patients this way:

Group I: 23 patients, given only colistin sulfate† oral suspension;

Group II: 15 patients, given colistin sulfate† after other antibiotic therapy failed. These patients were on other antibiotics for an average of eight days before being changed to colistin sulfate; and

Group III: 10 patients, given other antibiotics.

Empirical antibiotic therapy was started immediately after admission because of the toxic condition of the patients.

We were able gradually to increase the colistin sulfate† dosage up to 25 milligrams per pound per day when needed because the drug is not absorbed. No toxic effects were noted.

Eight patients in Group I also received sodium colistimethate† intramuscularly (Coly-Mycin®M Injectable). In these patients, *E. coli* sepsis was suspected because of the severity of diarrhea, lethargy, and toxic appearance of the patients. Intramuscular therapy was stopped when all blood cultures were reported as negative.

Patients were considered as having recovered when:

* This work is from the Newark Beth Israel Hospital where Dr. Fischman is chairman of the department of pediatrics and Dr. Semel is a senior resident.

** A special ward is established whenever the number of diarrhea cases exceed four.

† We used the Warner-Chilcott brand, tradenamed Coly-Mycin.

Three consecutive stool cultures were negative;

They became afebrile: and

Had formed stools.

All patients responded to therapy, but the time for recovery varied. Group I (which received only colistin sulfate†) recovered the fastest — 76 hours for the cultures to become negative — and had the shortest hospital stay (5.3 days). This group also had the lowest relapse rate: only two of the 23 or 8.5 per cent. Patients in Group II were switched to colistin sulfate† from other antibiotics (neomycin in 12 of 15 patients). They were on other antibiotics for an average of eight days before the change was made. This group had the highest bacteriologic relapse rate, 6 of 15 (40 per cent) for which we can offer no explanation.

The daily colistin sulfate† dose for six patients in Group II was increased from 7 to 25 milligrams per pound, when they did not respond bacteriologically or clinically. This higher dose was given for an average of six days. The median time needed to obtain negative stools was 60 hours (range, 48 to 120) after increasing the dose.

Group III patients on other antibiotics (mainly neomycin and kanamycin) were the slowest to respond to therapy. They remained in the hospital longest; and their relapse rate was 3 out of 10 or 30 per cent.

Pertinent data from the three patient groups are displayed in Table 1.

No adverse effects attributable to the antibiotics were seen. There was one sudden death in a child with nephrosis in a state of remission. (Her stool culture grew EPEC 055B5). Autopsy showed massive, bilateral pulmonary emboli as the cause of death.

Bacteriologic data for all of the 71 patients treated at our hospital during this epidemic are shown in Table 2.

TABLE II

Bacteriologic Data

Organism	No. of Patients
E. coli	48
Non-EPEC	35
EPEC	13
0111B4	7
0112B4	3
055B5	3
A. aerogenes	14
Proteus	2
Negative	7

Typical Case History

A 13-month-old girl was admitted with a history of ten watery bowel movements in the previous 12 hours. Diarrhea was preceded by a 24 hour period of lethargy and fever up to 103. Her birth was spontaneous after an uncomplicated full term pregnancy. Immunizations were completed at one year and she had no significant past medical or surgical history. Her weight at one year was 22 pounds. Her breathing was 36 and shallow. Pulse was 120. She weighed 19½ pounds on admission.

Physical findings: Shotty anterior cervical lymphadenopathy, hyperactive bowel sounds, poor skin turgor, sunken eyeballs, and warm and dry skin. During the examination the patient had a large watery, greenish-brown bowel movement. This stool and all subsequent ones were cultured, and the organism tested for sensitivity and sero-typed.

First Hospital Day: The patient was placed in the diarrhea ward, and an intravenous infusion was begun. She received 1000 milliliters of fluids in the first 24 hours and her state of hydration improved dramatically. Urine output rose from nil at admission to 25 milliliter per hour a day later. During the first 24 hour period she had six watery, greenish bowel movements. Initial laboratory data are shown in Table 3.

TABLE I

Summary of Antibiotic Therapy

Group	No. of Pts.	Antibiotic	Daily Dose (mg/lb)	Frequency (per day)	Time in hours for cultures to become negative	Bacteriologic Relapse Rate	Average Hospital Days
I	23*	Colistin sulfate	7	3	76	2/23 8.5%	5.3
II	15	Colistin sulfate after failure of initial therapy	7**	3	192	6/15 40%	12
III	10	Neomycin or Kanamycin	50	4	204	3/10 30%	17

* 8 of this group also received sodium colistimethate intramuscularly (5 mg/kg/day).
** Dose increased to 25 mg/lb/day (six patients).
† Warner-Chilcott brand, Coly-Mycin

TABLE III
Laboratory Data, "Typical Case"

	Initial	Day 1	Day 2	Day 6
Hemoglobin	13.5 mg %		10.9 mg %	11.2 mg %
Hematocrit	38%		32%	34%
White Blood Cells	15,600		10,400	10,600
Polymorphonuclear Leukocytes	72%		64%	52%
Stabs	4%			
Lymphocytes	20%		32%	44%
Eosinophils	3%		2%	1%
Monocytes	2%		1%	3%
Basophils	1%			
Sodium	135 meq	139 meq	142 meq	137 meq
Chloride	99 meq	103 meq	106 meq	107 meq
Potassium	3.2 meq	3.9 meq	4.1 meq	4.4 meq
Carbon Dioxide	10 mg/L	15 mg/L	20 mg/L	23 mg/l
Blood Urea Nitrogen	26 mg %			
Fasting Blood Sugar	78 mg %			

Second Hospital Day: The patient was started on colistin sulfate† orally at 5 milligram per pound every eight hours. She continued to receive fluids intravenously and was able to take some clear fluids by mouth. Only four loose stools were passed and she cried for her bottle. Blood electrolyte levels for day two are shown in Table 2. Urine analysis was within normal limits. Stool cultures grew EPEC (*E. coli* 0111B4).

Third Hospital Day: The patient was continued on colistin.† Intravenous fluids were discontinued and she was given clear fluids orally as tolerated. Four loose bowel movements, which were less in quantity, were passed.

Fourth Hospital Day: A diet of rice cereal, crushed bananas, cottage cheese and Jello® was started. Only two semi-formed brownish stools were passed.

Fifth Hospital Day: The diet was well tolerated and the patient's weight increased to 21 pounds. Two semi-formed brown stools were passed.

Sixth Hospital Day: Colistin sulfate† therapy was continued and the diet was unchanged. Three semi-formed stools were passed. Laboratory data for this day are shown in Table 2.

Seventh Hospital Day: Stool cultures from days four and five grew non-EPEC. The patient was discharged to be followed by the pediatric department. Colistin sulfate† therapy was continued. We added a mixed culture of Lactobacillus bulgaricus and Lactobacillus acidophilus in granule form. (Available through Hynson, Westcott and Dunning, tradenamed as Lactinex Granules®)

Mortality rates as high as 50 per cent have been reported[3] in previous epidemics of EPEC infection. Specific antibiotic therapy has certainly been responsible to some degree for the rapid decline in mortality in recent years. Most versatile antibacterials (initially used eight to ten years ago) were ineffective in the treatment of diarrhea due to most EPEC. Notable exceptions were sulfadiazine and streptomycin. Metzger and Jenkins[4] noted that it was not unusual to find that the tetracyclines and chloramphenicol failed to control the clinical illness. Resistant strains often developed during treatment.[5]

Neomycin was an effective agent. As Stalberg[6] and Wheeler[7] point out, this drug came into general use as the most effective treatment in outbreaks of EPEC diarrhea. However, the appearance of neomycin-resistant strains of EPEC was reported in 1950, 1962, and 1964. Colistin sulfate† has been shown[2] to reduce the population of neomycin-resistant EPEC in the stools of affected infants. While our *in vitro* studies did not disclose neomycin resistance, we found colistin sulfate the most effective drug.

As demonstrated by our experience, Group I (colistin sulfate only) patients responded most favorably, with a shorter hospital stay, than did any other group. While this also had been true in other reported outbreaks of EPEC diarrhea, unlike our study these reports[2] involved neomycin-resistant strains.

More important than specific antibiotic therapy, as a factor in the decrease of mortality, is electrolyte and fluid replacement for the severely dehydrated infants. It has been stated by others — and our experience certainly bears witness — that prompt and adequate evaluation and correction of the hydration state and electrolyte imbalance is imperative. Electrolyte and fluid balance must be restored. This principle was a major factor in treating our patients.

† Warner-Chilcott brand, Coly-Mycin

Summary

Experiences with a nine month diarrhea epidemic due to *Escherichia coli* are presented as a retrospective study.

Oral colistin sulfate† was the most effective of several antibiotics used in therapy as shown by the:

Least time for stool cultures to become negative;

Lowest bacteriologic relapse rate; and

Shortest hospital stay.

Where necessary patients received fluid and electrolyte replacement as a primary and essential part of therapy.

† Warner-Chilcott brand, Coly-Mycin

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519 Nye Avenue

Where To Go In Trouble

As cold and remote as the urban community may seem today, it can offer help for sudden or chronic problems — if there is a properly organized Information and Referral Service to guide people to the help they need. *Tell Me Where to Turn* is the title of a Public Affairs Pamphlet on the subject. The pamphlet, written by Elizabeth Ogg, may be obtained for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

The pamphlet underscores the need, in this time of rapid social change, for Information and Referral Services to direct people with problems through the maze of health and welfare agencies to the one that can best help them. Aside from the fact that the person in need — or the clergyman or doctor he has consulted — does not always know the most appropriate solution, Miss Ogg points out, "the search for service is often misdirected because the seeker has failed to see his key problem in clear focus. . . . People need first and foremost a skilled counselor with intimate and accurate knowledge of all the local agencies to help them sort out their most pressing problems and suggest what they can do."

Many calls for help can be handled in a few minutes on the telephone or face to face, Miss Ogg explains, "but a few require an interview in depth and several follow-up contacts with both the client and the agency to which the Information and Referral Service refers him, to make sure that he gets the services he needs."

For areas that do not have an Information and Referral Service, Miss Ogg provides guidance on how to set up such a program. She suggests questions to consider relating to auspices, purpose and program, financing, staff, use of volunteers. But beyond these considerations, she stresses that the needs of "the many who don't know where to turn" must always be paramount.

Here Dr. Moolten offers a compact monograph on the pathology of pneumoconiosis of especial interest to physicians in our state.

Industrial Pneumoconiosis In New Jersey*

Pathologic Manifestations

Sylvan E. Moolten, M.D./New Brunswick

Man's inventiveness in polluting his own environment is more than matched by nature's efficiency in purifying his lungs of inhaled particles. Coarse particles which gain access to the finer air passages are quickly removed by the film of mucus constantly formed in the bronchi and propelled by its ciliated epithelium upward to the pharynx[1]. Particles ranging between 0.5 and 5.0 microns, particularly between 1 and 2 microns, are the greater challenge because these can be drawn by inspired air into the alveolar spaces beyond the reach of the mucus blanket[2]. Such particles are also quickly eliminated, partly free, partly engulfed in alveolar phagocytes, upon a film of fluid secreted continuously by alveolar lining cells (alveolar surfactant). This film of alveolar fluid is drawn into the bronchi, perhaps by surface tension of the mucus blanket aided by rhythmic contraction of the alveoli[3].

Our problems begin when man defeats nature by subjecting his bronchi to the chronic irritation of smoking or when, through neglect, he lowers his resistance against viral and bacterial infection so that he becomes the victim of perhaps the most widespread epidemic of civilized society, chronic bronchitis.

My own studies with the isolated lung in the negative pressure chamber indicate that the interstitial tissue of the respiratory bronchiole constitutes a node of relatively high negative pressure during inspiration, capable of sucking surplus alveolar fluid and interstitial tissue fluid into the primary radicles of the intrapulmonary lymphatic tree[4]. When mucus is produced in excessive amounts and ciliary activity is depressed, as in the presence of chronic bronchitis bacteria and foreign particles entering the alveoli fail to be extruded with the mucus blanket. Instead they may be sucked with alveolar fluid into the interstitial tissues of the respiratory bronchiole, where they lodge permanently and excite inflammation and fibrosis or migrate within the lymphatics to the regional lymph nodes.

When irritant gases such as sulfur dioxide or nitrogen oxides are adsorbed to inhaled carbon and other dust particles they magnify the severity of inflammation in the interstitial tissue.

Interstitial fibrosis results in blockage of normal flow of tissue fluid and induces degenerative changes in the pulmonary parenchyma culminating in focal destructive emphysema. This complex of dust inhalation, abetted by adsorbed irritants and by chronic bronchitis, comprises the basic pathogenesis of pneumoconiosis. For this reason it is no longer valid to draw conclusions on the effects of occupational dust and air pollution exposure[5] without also considering antecedent factors responsible for chronic bronchitis, particularly the smoking habits of those exposed[6]. Centri-

* Read before the Sections on Chest Diseases and Clinical Pathology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 19, 1969. Dr. Moolten is Director of Laboratories, Middlesex General Hospital and Clinical Professor of Pathology, Rutgers Medical School.

lobular emphysema (which is commonly associated with chronic bronchitis) multiplies the hazard of dusts and bacteria by its trapping action on particulate material. The trapping effect is a pronounced feature of coal miner's pneumoconiosis[7], and can be readily demonstrated in the isolated emphysematous lung with India ink[3]. The potentiating effect of associated infection in pneumoconiosis is nowhere better demonstrated than in the pathogenesis of "progressive massive fibrosis", which, in fact, is also referred to as "infective pneumoconiosis." Although tuberculosis has long been assigned major responsibility for this complication[8], the evidence for tuberculosis is lacking in many cases of infective pneumoconiosis. This is indicated by the negative skin test with tuberculin, failure to find acid fast bacilli in the lesions, and the absence of characteristic histologic features of tuberculosis in a large proportion of such cases[9].

The mechanisms through which the interaction of inhaled dusts and infection incites massive fibrosis are obscure. One observer has suggested that the potentiating effect of retained silica in the lung may be likened to the action of Freund's adjuvant in facilitating the development of tissue hypersensitivity to antigenic substances[10]. Another possibility is that foreign particles in the lung constitute a form of microtrauma which favors the localization of circulating immune complexes. This is the Auer phenomenon[11]. This mechanism is epitomized in Caplan's syndrome[12], described originally in Welsh coal miners. In this disorder, massive rheumatoid granulomata occur in the lungs of subjects with various types of pneumoconiosis who suffer coincidentally from rheumatoid arthritis.

Vascular lesions are common in progressive massive fibrosis. Densely hyalinized scar tissue presents a formidable obstacle to blood flow. Vascular lesions may also appear over and above specific collagenous nodules[13]. These vascular changes may become an important factor in the genesis of *cor pulmonale* and play an important role in the ischemic necrosis which causes massive blocks of anthracotic scar tissue to soften and form cavities.

In miners' pneumoconiosis, prolonged exposure to coal dust may produce relatively little disability in the absence of chronic infection. Exposure to silica may also be well tolerated. In the lungs of many long term miners the pulmonary tissue contains surprisingly large amounts of particulate silica without having provoked any appreciable reaction[14]. The attack rate each year of any form of silicosis is only about 3 per cent of those who have been exposed to silica ten years or longer[15]. This apparent immunity to silica, which must be regarded as of widespread occurrence, is difficult to reconcile with the theory that silica *per se* is a poisonous substance, and once again throws the spotlight on coexisting chronic infection.

The classic silicotic nodule is easily recognizable histologically in the typical "ball of twine" silicotic tubercle. Studies of Vigliani[10], Curran[16], and their associates, suggest that alveolar phagocytes which engulf silica particles become "mummified" and are thereby rendered antigenically foreign. An autoimmune response is generated in which plasma cells, accumulated abundantly about the lesions, produce beta and gamma globulins. These globulins deposited upon and between collagen fibers account for about 60 percent of the material forming the silicotic nodules. Coincidentally blood globulins are elevated and a positive latex test for the rheumatoid factor is commonly found.†

The beryllium lesion is rarely observed in the United States because of legislation restricting the use of this metal in industry. Its irritating properties are striking. The acute reaction in the lung resembles chemical pneumonia[17]. In the chronic form, the diffuse pulmonary reaction is accompanied by numerous scattered granulomatous lesions. The suggestion has been made that the combination of beryllium with body protein results in formation of an

† Accordingly the presence of a positive latex test in a pneumoconiotic subject should not be taken as proof of rheumatoid disease of the lung or Caplan's syndrome without other evidence.

antigen which stimulates the formation of a beryllium-specific antibody. This makes it possible to utilize a beryllium patch test diagnostically[18]. An important concern of berylliosis to the pathologist is its differential diagnosis from sarcoidosis, which it mimics in surprising degree.

The list of dust diseases which are the byproduct of an industrial civilization grows each year. Talcosis is now regarded as part of the larger complex of asbestosis because of the presence of tremolite, a type of asbestos found in most commercial talc used in this country. Other dust diseases result from prolonged exposure to dusts containing aluminum, graphite, kaolin, carborundum, quartz, hematite, shellac particles, and dusts from moldy hay or maple bark.

Perhaps the most exciting chapter in the pathology of dust diseases of the lungs is found in the newer knowledge of asbestosis. Physicians in New Jersey in particular should interest themselves in the clinical and pathological features of the disease because of its high incidence in certain parts of our state and its serious threat to health, not only as a disabling form of pneumoconiosis but also because of the unique threat of late cancer. A prodigious wealth of information about asbestos is contained in the report of the international symposium organized through Dr. Irving Selikoff in 1964.

The asbestos body (the classical evidence of asbestosis) gives only an approximation of the extent and severity of the disease. In all likelihood the finer asbestos fibrils, much more elusive to the microscope, are more dangerous, particularly those less than 0.2 microns in diameter because of their capacity to penetrate deeply into the tissues. According to Selikoff[19] asbestos fibers can migrate widely and are demonstrable in the bone marrow, kidney, liver, adrenals, spleen, and gastrointestinal tract. Demonstration of such fibers requires highly refined technics including electronic ashing and use of phase contrast microscopy and x-ray diffraction methods.[20] In ordinary hospital practice pathologists must still depend upon their skill and patience in searching for asbestos bodies in pulmonary tissue or in sputum. Actually, the detection of asbestos bodies in the sputum was reported in this country as far back as 40 years ago[21]. Asbestos bodies can be demonstrated in the wet mount of fluid from formalin fixed lung tissue subjected to a brief period of maceration in water in a Waring® blender (seconds at low speed). The bodies stand out as refractile golden brown beaded rods in the unstained preparation[22]. Prussian blue stain for iron facilitates their detection in routine sections of lung or in sputum concentrates.

One of the most useful clues to the diagnosis of asbestosis is the presence of hyalin plaques. These interesting structures occur principally upon the parietal pleura including the leaves of the diaphragm. When they undergo calcification they may be detected in routine chest films. Although they may result from causes other than asbestosis, their association with asbestosis occurs so consistently that the diagnosis of asbestosis must be considered in every case until excluded by thorough examination of pulmonary tissue.

Although it is commonly assumed that the major lesions in asbestosis are in the lower parts of the lung, no part of the lung is immune.[23] The fibers tend to migrate toward the cortical and subpleural portions of the lungs, including the apices as well as bases. Because of their smaller size, chrysotile fibers are probably more dangerous than other types of asbestos fiber. Asbestos fibers, being needles, tend to be caught in the alveoli derived directly from respiratory bronchioles,[24] where they excite progressive fibrosis radiating into the surrounding parenchyma in more or less linear fashion in contrast to the nodular lesions of silicosis. The lesions are easily recognized by the presence of myriads of golden brown granules which take a deep blue stain for iron. Asbestos bodies may be embedded in the scar tissue or lie free in the contracted alveolar ducts in loose clusters. Heavy inhalation of asbestos dust is a cause of widespread conglomerate pulmonary fibrosis so that the patient suffers from progressive respiratory in-

sufficiency which may be aggravated by extensive pleural fibrosis. Death results from ventilatory insufficiency, secondary suppurative disease and pneumonia, or chronic cor pulmonale. Extensive pulmonary fibrosis caused by asbestos has become a rarity because of greatly improved methods of dust control in the asbestos industries.

What concerns us now and increasingly in the future is the time bomb of asbestos-induced malignancy. This problem arises in cases of lesser degrees of exposure which permit longer survival. An average period of about 20 years may elapse between initial exposure and the appearance of lung cancer.

Less intense grades of asbestosis and minor or even trivial ones are more likely to be associated with localization of lesions in subpleural sites and therefore with pleural plaques and malignant mesothelioma rather than involvement of the lung parenchyma by fibrosis or carcinoma[25]. According to Selikoff the duration between asbestos exposure and mesothelioma averages 38 years[26].

Carcinomata of the lung in asbestosis are of various types. In a series of eleven cases collected by Cordova *et al.*[27] there were five cases of adenocarcinoma and terminal bronchiolar cell carcinoma, three of squamous cell carcinoma, one case of small cell carcinoma and two of undifferentiated carcinoma. In two of their cases (and in several reported in the literature) the carcinoma in asbestosis was multifocal in origin. In my own experience the cancers have in general been highly anaplastic primitive carcinomata of epidermoid or alveolar cell origin arising peripherally in areas of asbestotic scarring.

One might perhaps consider the pleural plaques as a kind of benign tumor of mesothelial cells. The dense cartilage-like character of the plaques may conceivably represent the slow deposition of hyaluronic acid secreted by mesothelial cells upon and between collagen fibers, although this remains to be determined. The striking correlation between mesothelioma and asbestosis was brought to the attention of physicians and public health authorities by Selikoff, Churg, and their associates[26] in this country and by Wagner[28], Webster[29], and others in Great Britain and South Africa.

The histopathologic features of asbestos-associated mesothelioma, as described by Churg, Rosen, and myself,[30] are fairly characteristic. Diagnosis is doubtful only in the exceptional case in which a particular cell type dominates the field and suggests alternative possibilities such as metastatic carcinoma, fibrosarcoma, or nonspecific reactive mesothelial hyperplasia. More commonly, the malignant mesothelial cell reproduces in caricature some of the biologic features of the benign mesothelial cell including the secretion of hyaluronic acid and the formation of myriads of minute celomic cavities. Intractable pleural effusion is a characteristic feature of many cases. The fluid is not unlike synovial fluid because of its high content of mucin-like hyaluronic acid. Autopsy reveals massive encasement of such fluid in a thick shell of mesothelioma covering the entire parietal and visceral pleura of one lung. Mesothelioma arising in the peritoneum produces similar massive encasement of abdominal organs and omentum.

The most common histologic pattern is "biphasic", in which epithelium and stroma proliferate side by side. Variants of this occur when the tubules are few and are embedded in solid sheets of cells resembling fibrosarcoma. Among purely epithelial patterns are papillary and tubulopapiliary forms which are reminiscent of ovarian carcinomata. The stroma, especially in the biphasic types, may contain large quantities of intercellular material and may present as massive hyalinization, much like the dense hyalin of the benign pleural plaques. The ground substance in these areas is rich in mucopolysaccharide which stains strongly with colloidal iron and metachromatically with toluidine blue or thionin. These staining reactions are abolished or much reduced by previous digestion with hyaluronidase.

Gastrointestinal cancer occurs in three-fold the expected incidence in patients with as-

bestosis[31]. Other tumors reported in cases of asbestosis include carcinomas of the ovary, adrenal, and kidney,[32] and lymphoproliferative malignancies such as lymphatic leukemia, lymphosarcoma, and myeloma[33]. There is suspicion also that asbestosis is associated also with increased incidence of cancers of the oropharynx and pancreas[34]. My own series includes also one case each of leiomyoma of the duodenum, multiple leiomyomata of the small intestine, lipoma of the bronchus, bilateral pheochromocytoma of the adrenal, and adenoid mucoid carcinoma of the esophagus. In addition there were two cases of multiple myeloma, two of myeloproliferative disease, and a case of Waldenström's disease. These unusual evolutionary patterns of malignancy in cases of asbestosis may warrant special study for whatever light it may shed on problems of carcinogenesis in general.

There is much indirect evidence that the asbestos needle in itself does *not* possess the property of inducing malignancy. The small size of the particle rules out the carcinogenic effect of simple contact with cells as in the case of embedded plastics. What may be the more plausible explanation is the remarkable adsorbing activity of the asbestos fiber. Chemical studies of asbestos indicate that fibers of different types are capable of adsorbing gases, liquids and proteins in concentrated form[35, 36, 37, 38].

TUMORS ASSOCIATED WITH ASBESTOSIS
(Total Cases of Asbestosis 49; Cases with Tumor 33)

10 *Carcinoma of Lung*

12 *Mesothelioma*
- Pleural (7)
- Peritoneal (5)

5 *Digestive System*
- Carcinoma of rectum (1)
- Adenoid mucoid epithelioma of esophagus (1)
- Leiomyoma of duodenum (1)
- Multiple leiomyomata of small intestine (1)
- Hepatoma (1)

5 *Hematopoietic System*
- Multiple myeloma (1)
- Plasma cell leukemia (+ carcinoma of lung) (1)
- Myeloproliferative disorder
  - a. with lymphosarcoma (metastasis to brain and adrenal) (1)
  - b. with polycythemia vera and splenoma (1)
- Waldenström's disease with dysproteinemia (1)

1 *Retroperitoneal Embryonal Mixed Tumor*

33

It was once thought that benzpyrene was adsorbed naturally to asbestos fibers. Later it was shown that, at the site of mining, benzpyrene was lacking in the fibers. Instead oil from jute bags used in shipping contained benzpyrene which in turn was adsorbed in considerable amounts to contained asbestos fibers. Among the varieties of asbestos chrysotile has been found to have the greatest adsorbing activity for benzpyrene[37]. Other potential carcinogens adsorbed to asbestos fibers include several metal complexes, especially those containing iron. Iron dextran is highly carcinogenic in animals (Harington & Roe[36]) and hematite miners suffer from a relatively high incidence of lung cancer. Other potential carcinogens include nickel and chromium.

At one time asbestos was under consideration as a cigarette filter but this possibility was discarded when it was found to adsorb even the flavor of tobacco smoke. One might visualize innumerable small deposits of asbestos fibers in the finer air passages behaving as similar filters and concentrating large quantities of inhaled carcinogens from the environment. In this connection Selikoff, Hammond and others have shown a high correlation between the carcinogenicity of asbestos and the smoking habits of the patient[39].

An extensive bibliography of 39 references appears in Dr. Moolten's reprints.

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Youth did not invent problems of war, poverty, and racial discrimination. We did. We also invented the drugs and the pill.

The Identity Crisis Of The Advantaged Child*

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As physicians, we have always been aware of the crucial and transitional nature of adolescence both in its physical and emotional manifestations. We have not always thought of adolescence as a necessarily turbulent and rebellious period of life, though explosive physiologic changes have clearly been seen to have their parallel in rapid fluctuations of mood, energies, and controls. Yet this generation of adolescents demonstrates a depth of emotional crisis and reaction which differs significantly from that of previous generations. This is occurring at a time in the United States (and in many other parts of the world) when material advantages or affluence surround a great many of us. Affluence seems to perpetuate the dependent state in our young, postponing the necessity for assuming adult roles. We now have not only a great many adolescents, but we have them for a long time. The biologic transition is completed long before the psychological.

Other aspects of the affluent society in which we live may have serious implications for the development of adolescent personality. Witness these contradictions:

We are a society whose media continually provide sexual stimulation; yet there are numerous prohibitions against overt sexual behavior. We train our children to be obedient and abstinent for lengthy periods of time. Then we expect them suddenly to have sufficient aggressiveness to "get ahead" in a competitive world.

We emphasize competence as an avenue to status. But we keep our young from work experience and out of the labor market, which serves to lengthen extraordinarily the gap between physical maturity and economic and social effectiveness.

We are also increasingly an urban society in a constant process of social change and upheaval, with a similar rapid change of pace expected in social behavior and emotional adaptability.

Our society also allows numerous choices in life style and vocation, many models from which to choose, many options and many acceptable goals and these are increasingly open-ended. Small wonder, then, that father's model of life is not inevitably the child's.

And, finally, we add a crucial new factor to the vast speed-up of social change which is that our communication processes make technologic advances more real and urgent in our daily lives.

What, then, are the implications of these societal changes for affluent and advantaged youth?

Personal identity is often largely based on occupational choice. Before this choice is made in final form, one is often forced to improvise an identity or to assume a variety of changing identities. This may in part account for what is apparently a significant trend, a delayed entry into the institutions of society, vocational, social, even interpersonal, as evidenced by dropping out of school, taking menial jobs, and delaying legalized marriage. What is particularly distressing to many is the style which this fluctuating identity assumes —

* Read before the Section on Psychiatry and Neurology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 19, 1969.

the beards, the beads and the belligerence—and what makes this style even more conspicuously dissident is the style of the parents.

Affluent parents in 1969 are, on the whole, those who survived World War II and the Great Depression. These are people who moved to the suburbs to live in a child-centered, family-oriented, "safe and sane" community. These families, having acquired economic power with some effort, have become cautious, acquisitive, and overprotective. They were parents who often had excessive professional or business preoccupations, but who failed to impart to their own children the concept of socially useful work and who often made up for emotional unavailability with material overindulgence.

Material overindulgence and a reluctance to permit the child to experience frustration, or to delay immediate gratification, have found expression in numerous child-rearing practices such as demand feeding, delayed toilet training and uninhibited forms of "creative expression," all focused on anticipation of the child's needs, as though keeping a child always happy was the way to promote growth. But we seem to have forgotten that growth is often a product of frustration and hard work, and as Freud himself described the Reality Principle: the postponement of immediate gratification for future rewards.

Inability to delay immediate gratification in adolescence leads to a perpetuation of infantile patterns akin to temper tantrums. The ambivalent message to youth in our culture is: "Begin to achieve, but wait to perform." This frequently leads to a resurgence of anger and often rebellion. Ironically for children growing up in a materially overstimulating environment, status, affluence, even opportunity, often appear to be burdensome and limiting, especially in ego-building reality experiences.

Against this parental backdrop, espousal of a philosophy of nonviolence, brotherhood and love, with emphasis on spiritual as opposed to material values, with disregard for conventions of dress and deportment, is often perceived by parents as a brutal affront and mockery of their own achievements. At the extreme of the spectrum is the hippie who refuses to work for a living, though he may work at artistic levels for pleasure alone, and who openly denies the relationship between men and commodities.

The unique nature of adolescence in its search for identity lends itself naturally to a concern with large philosophical and abstract questions such as the meaning of God, the values of society, the purpose of life and the validity of our economic system. Bombarded by sexual and aggressive drives, the emerging ego is also struggling with the need to develop a capacity for thoughtful rather than impulsive action. Yet there is also a need to develop distance and withdrawal from parents and often parent surrogates, such as teachers. An attempt to develop adequate controls, in the framework of establishing their own autonomy, often involves a need for solidarity with their own peer group to give support and substance to their strivings.

This estrangement from the values of one's family and society has been labeled "alienation." It is a common occurrence in affluent youth, yet it can flourish only under particular circumstances. One can really pursue the eternal values of truth, beauty, love and meaning only when one's material needs have been satisfied.

Let us define the "Identity Crisis" of affluent youth, therefore, in the context of experimenting with a provisional or transient identity, a delayed entry, or even an escape from the structures and functions of adult life, what Erik H. Erikson,[1] has called a "psycho-social moratorium," which has the goal of solving certain problems of growth.

What we see in the forms of beats, hippies, drug users, unmarried marrieds, even temporary homosexuals may be youngsters who are experiencing a transient or even regressive withdrawal from social expectations and responsibilities. The costumes and the rites are

[1] *Identity, Youth and Crisis*, Erik H. Erikson, New York, 1968, Norton.

primarily a badge of identification, a token of group solidarity, a way of differentiating this subculture from larger society, often chosen for their sharp offensive, antagonistic qualities. What better badge of uniqueness than dirt in a society which spends millions of dollars annually advertising soap and deodorants? Yet beneath the uniform of nonconformity are often found true seekers of the truth, with high demands of themselves and of life. Often they are perfectionistic and even obsessional about the search for moral and ethical values, and may indeed suffer reactive or situational depressions when the search is unsuccessful.

Clinical symptoms often include an attitude which is bored, restless, apathetic or confused. "What's the use?" is characteristic of the passive, unhappy, and impotent youth.

On the other hand (and more disturbing), their behavior may take the form of rebellion, violence, drug taking, promiscuity, and other "acting out" in the form of cheating, lying, and stealing. Then again, passive withdrawal may at times lead to severe depression, with blocking in the ability to perform, most usually in the area of school achievement, and sometimes an actual retreat to bed and room. In this context drugs are commonly seen as a way of obtaining a rapid, magical cure.

This passive, aggressive quality of alienated youth may give us a clue as to the nature of the problems they are trying to resolve. These involve feelings of being unloved and untrusted; and feelings of anger at parents or at society which they perceive as restrictive, dishonest, punitive or intimidating. These feelings may result from the conflicting messages of our society as transmitted by parents. Although parents themselves may often be unaware of the contradictions in their own expectations, the message may read as follows: "Youth is the time for fun. Have a good time. Be popular. We only want the best for you! But be sure to get good grades, for that is the road to success!"

Much of the crisis of growth (or "identity crisis" if you will) center about a difficulty with competitive endeavors and with problems in the expression of anger and aggression. This is a central problem for our whole society, and the line of demarcation between competition, aggression, and violence is not clearly understood even by adults. Rebellion against competitiveness, institutional, political and military aggression, as well as against our technologic and materialistic society may therefore really be an attempt to free youth from those problems which limit their own personality development. Hence the symptom of passivity or "underachievement" must be seen as an act of hostility most often directed at parents. To this, the response of parents is ambivalent. They are both envious and angry. They cannot understand why their children turn to drugs, revolution, and even to synthetic solutions, why they do not find meaning and pleasure in school, jobs, church, or even leisure-time activities.

Our task as parents and physicians, however, is not to be angry and affronted, but to respect the identity crises as valid (albeit often unsuccessful) attempts in their growing up to deal with the contradictions and hypocrisies which confront them. War, affluence in the midst of evident poverty, educational systems of conformity, and all the other outcroppings of an irrational social structure such as a high divorce rate, mental illness, overt and covert crime, are real problems for our whole society. They were not invented by our youth.

Adolescents reject parental values, not only because of their natural need for growth and differentiation at this period, not only to attempt to resolve personality problems, but also because parental values do reflect the sins of the larger culture. The gap between promise and performance in our world is painfully apparent and dissent and disillusionment are not necessarily pathological.

To understand why this process of growth takes the forms it does, may tell us more about the stage on which adolescent struggles and change are being acted out, than about the crucial individual conflicts and motivations for the behavior. Youngsters of intelligence and good ego strength can sometimes avoid facing their internal problems by using alternatives such as community involvements,

Peace Corps and the like.

It is the adult world which makes drugs, alcohol, and contraception available. It is also the attitudes and values of peers and adults, enhanced through the mass media, which make the defiant, the forbidden, the abnormal such a pressure and fascination. Let us not focus only on the *style* of the problem. The long hair, the obscenities, the dress, and the drugs may obscure the content.

The central problem which *is* our legitimate concern seems to lie in the area of the fear of growing up, in a reluctance to loosen object ties to infantile or regressive patterns. Russell Baker of the *New York Times* has coined a neat phrase for this. He calls it "Imprisoned in Kidhood."

It is a kind of naiveté to feel shocked when we have given them everything that money can buy, and they say ungratefully that it is the wrong thing. Affluence which frees a child of responsibility for survival and security does often deprive him of real life experiences related to the need to achieve, to become competent, and to learn to cope. It does deprive him of challenge and of identification with the normally aggressive parent. It is therefore a roadblock in the creation of an adult identity. Affluence frees the child to explore his social, emotional, and intellectual life for a far longer period than was available to his parents. It also gives him a longer period of time to discover the growing problems of our social institutions.

The pathology lies less in rebellion, then, than in denying, shirking, or by-passing adolescent stress and turmoil in the service of freeing oneself from dependent and inappropriate attitudes and relationships. This can only result in a pseudo-adulthood, leaving problems to be solved at a later time of life.

I do not suggest that we adults will lighten all the developmental tasks of adolescence by bettering some of the world's ills, nor do I suggest that we accept as valid (or as final) youth's solutions. Their restlessness and the necessity for postponing real contributions to society will surely lead to exaggerations and excesses of thought and action.

But is it not possible that we may learn something about the nature of our world as we see if reflected in the tortuous complications it adds to the process of growth? Should we not be more aware of the quality of the environment as it places undue stress on our psychobiological systems?

If we adults can wrestle more honestly with these problems, we may make adult life seem a more desirable stage to attain. Our children may never take on the values of the establishment as we know them today. This is not to be construed as a failure in appropriate maturation. It may turn out that they will make a more profound and healthier adaptation to the realities of twentieth century life.

At least two commentators have even seen value in this period of protracted adolescence. Holmes[2] has suggested we may be able to keep alive for a longer period those imaginative, creative, and inventive faculties so much a part of adolescence and so often lost in later life except by a very few gifted artists. He suggests that we should not confuse normality with morality or abstinence with saintliness.

Soskin[3] sees this searching process of youth as a striving for some optimum mode of interaction between self and society. He adds that we may then learn to make fewer unreasonable demands on our environment, on the one hand, and, on the other, to modify or eliminate those institutions that do violence to man's internal harmony.

From the summit of our own maturity, we may prefer to see more appropriate solutions to the individual and social crisis of growth, change, and differentiation than the sometimes bizarre, raucous, or violent ones of today. But each generation spawns its own style of rebellion, and it behooves us to pay attention to the anti-materialistic, anti-intellectual, anti-establishment style and content of youth and its crisis of identity in 1969.

[2] "The Young Patient and the Solid Citizen Psychiatrist," Donald J. Holmes, *Seminars in Psychiatry*, 1:1 (February 1969)

[3] William F. Soskin, editorial in *American Journal of Orthopsychiatry*, 39:3 (April 1969)

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Does each generation of military surgeons have to learn over again the principles of wide excision, delayed closure, and copious irrigation?

Principles Of Wound Debridement:

Recent experience with civilian war casualties

Thomas P. Comer, M.D./Montclair

The principles of wound debridement are the product of war. Progress in surgery has been intimately associated with war and the conflict in Viet Nam will be no exception. The author has recently served as volunteer surgeon at the Da Nang Civil Hospital in Viet Nam where he was personally involved in the management of over a thousand war injuries.

Debridement literally refers to the unbridling of a horse.† The famous war surgeon, Paré, introduced the term into the literature. Debridement was practiced successfully and the term given its anglicized meaning by Depage[1] of Belgium during World War I. Presently the accepted definition[2] is the removal of all foreign matter and devitalized tissue in or about a lesion.

The experience of the First World War[1] was soon forgotten and had to be relearned in the 1940's. Surgeons in the Korean conflict were of a new generation and this was demonstrated by the increased morbidity and mortality rates coincident with the arrival of each new group of military medical officers.[3] Unfortunately, from our personal experience in Da Nang and in visiting many sites in Viet Nam, the lessons of centuries had to be relearned again.

†Lexicographers are not in agreement on this. Actually *debris* is of French origin, and comes from the same root as the word *bruise*, the literal meaning being "to break down" which corresponds pretty well with the concept of removing foreign matter, since *debris* is thought of as *broken-down* matter. *Bridle*, on the other hand, is cognate with the word *braid*. It seems likely that the *bride* in "debridement" has nothing to do with the *bride* in "bridle."—Ed.

Triage

Triage is essential in a mass casualty situation. With the use of axillary block for upper extremity wounds and spinal anesthesia for lower extremity wounds, our main triage division was into groups that (a) could be managed in the emergency room and (b) those requiring the operating room with the use of general anesthesia. With small kits, we were able to administer axillary blocks and spinal anesthetics in the emergency room and accomplish satisfactory debridements of the extremities leaving the operating room free for the more serious cases. Blood was generally not available. Ringer's Lactate solution, as shown by the work of Shires[4] proved to be good replacement fluid. Hypovolemic shock was common. Renal shutdown was not a problem though we have no good explanation for this.

Debridement

The prime principles of debridement are wide local excision, copious irrigation, and immobilization. As new physicians arrived, their first attempts at debridement were usually unsatisfactory because of insufficient removal of tissue. Skin tolerates trauma well and only a few millimeters need be sacrificed about the edge of the defect. The importance of this minimal excision becomes evident when delayed closure is performed. Fat may be removed with impunity; and as a rule of thumb, it is almost impossible to remove too much. Fascia should be widely incised. The next layer encountered is that of muscle and it is in this area that the vast majority of errors are made. There is no substitute for experi-

ence in judging the amount of muscle to be removed. Criteria are available which proved helpful to us. Scully, Artz, and Sako[5] found the best clinical index of viability to be the *consistency* of the muscle. Nonviable muscle rapidly becomes "mushy." Significant also is the ability of the muscle to contract and bleed when cut across. Vigorous contraction and bleeding means viable muscle. Color proved to be the least reliable index. Generally, the errors made were too much removal of skin and too little muscle.

High velocity wounds can be deceiving. We have found the size of the wound of exit as a useful guide to the velocity of the missle.

Bone with periosteal attachment should be preserved. Although it has been recommended that free fragments of bone be replaced,[6] we found that free fragments in the wound generally became the nidus of infection and had to be removed at a second operation. Tendons and nerves should not be sacrificed. Debridement of joints should be especially thorough and the capsule may be closed without drains. Saphenous vein grafts proved very satisfactory for repair of arterial damage which could not be accomplished by end-to-end approximation.

Delayed Primary Closure

Lowry and Curtis[7] found that even after complete excision was performed, 50 per cent of war wounds which were closed primarily became infected. It would appear unnecessary to state that all war wounds closed primarily without debridement meet with disaster. Yet each week we would see several casualties in the emergency room who had had primary closure in the field. We feel most strongly that traumatic wounds should be left open and closed secondarily in five to seven days. Because of overwhelming numbers of casualties during the heavy fighting, we often could not close the wounds in five to seven days and our experience in later closure is in complete agreement with Bick[8] who aptly observed, "The days of proudly exhibiting good healthy granulation tissue have become as archaic as have the days of 'laudable pus'." In civilian practice with facilities and time available, one may be tempted to try debridement along with the irrigation with several antibiotics in the hope of achieving successful primary closure. We cannot condemn the practice too strongly as the time saved if successful is minimal and the possible consequences if unsuccessful may be disastrous. It may serve the surgeon's ego well but the possibility of a disastrous infection with loss of an extremity or even life is too high a price to pay.

Summary and Conclusions

The war in Viet Nam has shown again that the experience of wound debridement is not handed down from one generation of surgeons to the next. The price of relearning these principles is a high one.

We have stated the principles of wide local excision, copious irrigation, immobilization, and delayed primary closure which served us well. Failures in the handling of trauma were usually secondary to a violation of one of these principles.

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333 Park Street

A knowledge of sexuality is not simply a knowledge of reproduction, information about eroticism, or an understanding of genitalization. It is much more, and the physician has a prime role to play here.

Role Of The Physician In Community Sex Education Programs*

Mary S. Calderone, M.D./New York

SIECUS, the Sex Information and Education Council, was founded in 1964 as a voluntary health organization, supported by foundation grants and private donations. Its goals are: "To establish man's sexuality as a *health* entity; to identify the special characteristics that distinguish it from, yet relate it to, human reproduction; to dignify it by openness of approach, study, and scientific research designed to lead toward its understanding and its freedom from exploitation; to give leadership to professionals and to society, to the end that human beings may be aided toward responsible use of the sexual faculty and toward assimilation of sex into their individual life patterns as a creative and re-creative force."

To achieve this purpose, all elements of our society must give careful thinking about reorienting themselves to sex and sexuality and their purposes in life. The acceptance of SIECUS and the heavy demands on it have been such that it has found itself playing a role as a social force.

Many people erroneously believe that the schools have been the major focus of SIECUS interest. This is not so, for in a real sense, this focus was forced on SIECUS by heavy demands from schools. SIECUS does not focus specifically on any major component of society, believing rather that *all* elements should be involved in reconsideration of this central part of all of our lives. Requests for services of all kinds, around 600 per month, come from medical schools, medical societies and academies of general practice, religious institutions, universities, and teacher training institutions, PTA's, and from communities as a whole. The SIECUS Board itself represents varied elements from which come expressions of interest, being made up of 50 representatives from the medical, religious, educational, behavioral science, legal, and other professions.

SIECUS responds to most community requests by assisting a community to organize its own initial and continuing program, using the resources already available to it. A 1968 Conference on *Sex Education, Sexuality, and Mental Health* was initiated by the Mental Health Association of Essex County, New Jersey, but was cosponsored by 45 other organizations from the surrounding area including six Boards of Education, the Board of Rabbis, the Episcopal Diocese, a Department of the Roman Catholic Diocese, four Welfare Departments, the County Medical Society, and many service, educational, and religious organizations. Work sessions centered around such central topics as sex education at elementary, high school, and college levels; sex, love, and life styles of the mature adult; moral

* Given at combined annual meeting of the Bergen and Passaic County Medical Societies. Saddle Brook, March 11, 1969. Dr. Calderone is the Executive Director of the U.S. Sex Information and Education Council.

codes; sexual attitudes and behavior; family life and sexuality; and so on.

What does such an in-depth community activity tell us? That, in recognition of our own ignorances and failings of understanding about sexuality (and out of concern for our children), we are engaging in re-education of ourselves with respect to it—with the three major groups engaged in this reeducation being physicians, clergy, and educators. We must recognize as untenable the way we have consistently equated reproduction and sex. Education about reproduction is not sex education.

A further error was that erotic or physical aspects of sex represented the totality of sexuality. Another error was that sexual morality means no sexual feelings of *any* kind permissible until the marriage ceremony, as if it were desirable or even possible to go through childhood, adolescence, and young adulthood as a neutral, nonsexual person. Understanding is needed of how sexuality develops in the individual and some of the forces that play a role in its evolution.

A newborn baby is sexually undifferentiated, except anatomically. When the newborn emerges from the womb, we assign it to the male or female sex according to his or her genital organs. But the actual process of turning him into a total man or a total woman begins at that moment, and will depend greatly on how his parents and the other adults in his life deal with him. The sexualization of the child begins immediately at birth to be imprinted on him by expectations, from his mother especially, of behavior considered appropriate by her and later by the father and by others, to the state of maleness or femaleness. These expectations will differ according to the cultural group to which the child belongs.

The baby with the external genitalia of a male does not automatically grow up to have the nature and feelings of a man as defined by his cultural group. He has to be made that way. We know that this is so because of evidence brought to us by cultural anthropologists. We also know this from what happens if a baby is born with external genitalia that although anatomically male, may, because of certain malformations (bifid scrotum and small, hypospadic penis) actually mimic the genitalia of a baby girl. If the physician is careless or unaware of this possibility, he will inform the parents that they have a girl instead of a boy. Instantly they begin to "build in" to this baby their own attitudes and expectations based on their knowledge that she is a girl and will behave as one, and this continues until early puberty when they become aware that "her" voice is deepening, the breasts are not enlarging, she does not menstruate, and that what the physicians had told them was a perhaps over-prominent clitoris has begun enlarging. But "she" has been brought up as a girl, thinks as a girl, feels as a girl, identifies as a girl, is psychologically female. The same thing can happen to a girl mistakenly identified at birth as a boy.

The converse of heterosexuality is also built into the growing child who, at birth, has been correctly sex assigned: this is homosexuality, the sexual attraction of a person by and to a member of his or her own sex. I am not speaking of the homosexual feelings or even behaviors that most of us experience at one time or another in our childhood and adolescence, but rather the fixed homosexual orientation that has been built in by the way a particular child has reacted to the relationships between the parents and between them and himself. These are two of the many bits and pieces of scientific evidence that tell us that the making of a man or a woman should not be left to chance, that the question of gender identity is not merely one of organs or hormones but of a long psycho-dynamic continuum that we can call *sexualization*. Heterosexuality, like homosexuality, is not born but made.

Let me differentiate between three areas that relate not only to the psychosexual evolution of the individual but will also have a great deal to do with our understanding of what

planned sex education might consist of: reproductivity, genitality, sexuality.

Reproductivity relates to the capacity of the individual to impregnate or to be impregnated and its onset is signalized by menstruation and ejaculation. The process of reproductive maturation is absolutely automatic. It will happen regardless, but our great error is to equate it with total maturation. This is one of the bases for the confusion of behavior exhibited by many adolescents. A girl is not a little woman when she first menstruates, nor does ejaculation mean that the boy has become a man; far from it.

Genitality is the localization of sex sensation at the genital level eventually culminating in the sharply defined experience called orgasm. Genital maturation or genitalization is also automatic in the male. By definition, the ejaculation that appears at puberty could not take place without orgasm. Many males often begin genital response long before puberty, however, with erection in infancy and early orgasm in masturbation.

In females, genitalization follows a different and non-automatic pattern. Fewer females than males have genital sensation in youth, although many do experience orgasm quite young in masturbation. However, the largest group experiences first orgasm in the late teens or considerably later. This bears no relation to the onset of reproductive maturity, unlike in the male. Furthermore, the female's genital response is less likely to be physically oriented, is more apt to be a learned rather than a spontaneous experience, learned in many cases only after a good deal of sexual experience, and occasionally never.

Another major difference arises in later life. Once established, female sexual response tends to rise and remain at its peak intensity throughout most of the rest of her life cycle. The male's, having reached its peak intensity in the late teens or early twenties, tends thereafter gradually to diminish.

Reproductivity and genitality have tended to be regarded as the whole of sex. The concept of sexuality as the totality of expression of the individual's entire self as male or female is, I believe, the essence of the purpose for which SIECUS was established. It is not a concept new to science, of course, but unless all of us can keep ourselves firmly and constantly oriented to the concept of *sexuality as part of the total personality,* we will continue to bog down as so many have done, in the purely physical, biological, and erotic.

The processes of reproductive and genital maturation are highly complex in themselves and cause young people a great deal of stress, particularly when no one has been wise or generous enough to provide them with a sound basis for understanding their nature. But as if these were not enough, other maturation processes are going on pell mell during the same critical sex years of adolescence: *physiological* maturation by which the body grows and changes at a fantastically rapid and uneven rate; *intellectual* maturation, the acquisition of knowledge and ideas, the development of the ability to reason, to think in abstract terms, to apply knowledge in concrete terms; *emotional* maturation, development of the capacity to feel, to love, to relate, to sacrifice, to accept responsibility for another's welfare; *spiritual* maturation, by which the young person develops aspirations, ideals, responsibility, a sense of purpose, and place in the universe. Formal education can partly affect, modify, or compensate for deviations in most of these processes. The child's immediate environment does most in terms of attitudes and understanding — or lack of them. Sexual education of the child and young person is going on continuously from birth. Attitudes, behaviors, and relationships of the men and women in his life, especially his parents, constitute his earliest and most potent sex education. The way they see and treat each other as man or woman, their self concepts of themselves as male and female — these are powerful nonverbal sex education, often negative or distortive. Coupled with the invasive continuing influence of the television set in the home, the child comes into kindergarten with a great

deal of powerful sex education already, distorted or fearful, having observed sex to be of obsessive concern to adults even though he himself is never free to speak or inquire, much less feel about it.

The net result is a distortion of the orderly sequence of the maturation processes, with erotic maturation or genitalization way out ahead of the others (intellectual, spiritual, emotional). Today we see clergymen, physicians, and educators baffled as to how society can continue thus to hothouse or force erotic maturation in the face of the evidence of the destructiveness of such an imbalance. We see this evidence in the increasing scale of sexual activity embarked on at increasingly younger ages, and earlier and earlier in the "dating" relationship. But other pieces of evidence are more subtle and disturbing. For instance, the growing incidence of impotence in young males (married and unmarried) during the 19 to 30 year old span when they should be at the peak of their potency, and also in the older male. There is also the big question of masculine and feminine identity in which the characteristics of masculinity and feminity are becoming less distinct from each other with, in many instances, diminished or more passive sexual interest. Powerful, distortive influences are at work, and often the ones most highly affected are the intellectual sector — the most able young people who, intellectually and emotionally, repudiate the many false gods that the adult world has set before them: worship of money, things, status, physical genital sex, success, competitiveness based on hostility, and complete lack of concern for, or even awareness of, the needs of others that inevitably leads to hostility and violence whether between nations, religions, races, husband and wife, parent and child.

Profound changes in society cannot be resisted by going back to horse and buggy methods. We must enlist ourselves *with* our young people to try to help them with the job of living personally and with fulfillment and responsibility in a computerized, depersonalized world of startling knowledge accumulation. Let's face it: man is technologically obsolete in comparison to his machines. The slow, precious process by which humans learn to relate to each other in intimacy and love cannot be computerized or speeded up or mechanized. Neither can the slow precious process by which the human being evolves from the sexually undifferentiated baby into the mature, responsible adult male or female. This process just can't be speeded up, forced, or computerized either.

This slow precious process is all we have left with which to hold on to our sense of our own selves. If during this long maturational process, genitalization proceeds too far ahead of the whole of the other processes (if sex precedes and outstrips sexuality) then we will continue to see our children and our grandchildren paying the price for what we ourselves have allowed to happen.

The Role of the Physician

Physicians have important roles to play in the reconstruction of society's attitudes and knowledge about human sexuality. The doctor of medicine must accept his leadership role in helping his community understand that school and church must play their part in sex education programs. He and his medical colleagues can join with the clergy in testifying to the need by young people of adequate programs. The physician can lend his strength and knowledge to program planning and teacher orientation; he can find opportunities to share with parent groups the conviction that, when we accord to our young people the dignity of confidence in their ability to make sound use of sex information, they rarely fail to return this trust by developing good judgments and values that in the end serve as their own best protection. In particular, he can help parents realize that, with the complexity of the world as it is today, parents themselves are not equipped to do the entire job alone. The school and the church can, by supplementing the parental effort, support the parents in their role so that family communication may actually be strengthened thereby.

All of this requires a good deal of physicians — in acquisition of knowledge regarding the sexual development of children and adolescents, and about the sexuality of adults of all ages. This society has allowed itself to become lost in a miasma of blind fear and mythology about sex on the one hand, and in a sea of eroticism on the other. Medical schools and official bodies such as the American College of Obstetricians and Gynecologists and various graduate medical programs are all beginning to consider this area as an integral part of the training and preparation of physicians. The time has come for physicians to stand up and be counted on in the need of all the members of the society, but particularly of the young people, for education toward responsible and mature sexuality. Sex is an essential component of life, to be looked upon as the great cementing experience in marriage, with many aspects — joyous, fun, funny, healing, and deeply meaningful in human relationships until the end of life. If adults fail to establish honest communication about these vital issues with our young people now — any later will be far too late.

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1855 Broadway

Economy Incentive For Blue Cross

Connecticut hospitals have agreed to test a new method of payment with built-in incentives for efficiency and economy. It involves payments under Medicare and Blue Cross.

In this experiment, each hospital sets up target budgets for the departments involved in the project. These are departments over which the hospital has the greatest control and which account for about 60 per cent of a hospital's costs: room and board, laundry, housekeeping, medical records, and so on. Hospitals whose costs are under the target budget will receive the budgeted amount. Those on target or above will receive their actual costs. In addition, a hospital which operates a department at 10 per cent or more below the average costs of its peer hospitals will receive a reward of up to 2 per cent of the department's actual costs.

The departmental budgets submitted by each participating hospital will be reviewed and approved by a special board of local hospital administrators, comptrollers, directors of nursing, and hospital trustees. In approving a department's budget, this tribunal will consider costs in prior years and the expected productivity levels set by industrial engineers.

A council of consumers and representatives of Medicare, Blue Cross, and hospitals not in the experiment, will oversee the operations of each hospital Budget Approval Board to assure compliance with the experiment guidelines and the quality of review.

The effect of the experiment on costs and quality of care will be evaluated by the Yale University Department of Epidemiology and Public Health.

In all the English language literature only five cases of carcinoma have ever been reported associated with the regional ileitis. Here is a sixth case.

Carcinoma Associated With Terminal Ileitis

Max Magnes, M.D. and Peter DeBell, M.D./Paterson

Since the first published reports of regional ileitis by Crohn in 1932, the condition has been found to be more prevalent than originally expected. But, in all the available literature, only five cases have been reported of a carcinoma superimposed on an ileitis.

Here is a case history of a patient who was found to have regional ileitis at operation when he eventually became obstructed and surgery was imperative. A 71 year old man was first seen in 1957 because of diarrhea of four years duration. He had, typically, four loose bowel movements in 24 hours. He had no abdominal pains and no rectal bleeding. His weight was constant. Abdominal examination revealed a palpable mass in the right lower quadrant. X-ray showed that the terminal ten inches of the ileum were narrow and rigid. The patient was given steroids and his condition subsided. He felt well until 1959 when he had a recurrence of his symptoms. On steroids, his condition again subsided with one normal bowel movement a day. But in 1964 he began to develop infrequent abdominal pains although he only had one loose bowel movement a day. At this time, x-ray showed a chronic duodenal ulcer and terminal ileitis. He was placed on therapy and his pains subsided. But in 1966, his diarrhea recurred. At this time, x-ray showed the terminal ileum to be narrow and rigid for a distance of about twelve inches. He was again placed on steroids with an aluminum hydroxide gel. In March 1968, he had a mild recurrence of his diarrhea and x-ray showed the same findings in the terminal ileum as that of 1966 with no change in the appearance of the ileitis. In July 1968, the patient became constipated but he had no rectal bleeding. Then came severe attacks of pain which occurred every few weeks and required 100 milligrams of Demerol® for relief.

An operation in December 1968 disclosed an area of ileitis extending from the ileocecal valve for about four feet proximally. The ileum was scarred and thickened. There were numerous enlarged nodes in the mesentary. The intestine proximal to the area of involvement was distended indicating obstruction. The liver seemed normal. Dr. W. B. Hahn, our pathologist, reported that the specimen was a segment of terminal ileum with attached small portion of ascending colon. About 40 centimeters from the proximal line of resection, the serosal surface presented irregular scarring, greyish white in color, and firm in consistency. The entire serosal surface of the cecum was greyish-tan, dull, markedly edematous, and partly covered by few hemorrhagic fibrous adhesions. The lumen contained a small amount of hemorrhagic soft fecal material. Corresponding to the serosal scarring, the mucosa of the small intestine had a greyish-tan, partly necrotic fungating mass which almost completely obstructed and encircled the lumen of the intestine. Proximal to this area, the small intestine was markedly dilated.

Distal to this mass, the terminal ileum was narrowed but the ileo-cecal valve was well

preserved. The colonic mucosa was congested and slightly edematous. In its proximal portion, the mucosa was markedly edematous with shallow ulcerations, the largest measured up to 15 millimeters in its greatest diameter. A small polypoid structure was seen just proximal to the mass. This fungating irregular mass was partly necrotic and rather polypoid in character, raised two centimeters above the mucosa. The base of this mass was partly ulcerated and covered by necrotic and hemorrhagic debris. On section through this mass, the cut surface was greyish-white, and the tumor mass extended throughout all layers of the bowel wall. In the remainder of the small intestine distal to this mass, the mucosal surface was congested and showed several small polypoid structures. The lumen was markedly narrowed. The distal portion of ileum had numerous irregular shallow ulcerations of erosion of the mucosa. The wall was markedly thickened. The resected segment of the ileum and cecum showed infiltrating adenocarcinoma, multiple benign ulcers of the small intestine, and inflammatory polyps.

Summary

This is a 71 year old patient who gives a history of terminal ileitis since 1957 who had first responded to steroids but in the last year developed episodes of partial intestinal obstruction. After he was prevailed upon to submit to surgery a concomitant carcinoma was found associated with regional ileitis. Oddly enough, he also had a duodenal ulcer which is not a common finding with regional enteritis. Bockus[1] said that only five cases of intestinal carcinoma have occurred in association with regional enteritis as recorded in the literature. "Of the approximately 5,000 reported cases, only 0.08 per cent were associated with cancer. This is less than the expected frequency since the incidence of cancer of the small intestine in the absence of regional enteritis is 0.1 per cent. The small intestine is not a common site for carcinoma under normal conditions although it occurs with more frequency in ulcerative colitis but not in granulomatous colitis"

[1] *Gastroenterology*. Henry L. Bockus. Second Edition. Volume II. Philadelphia, 1960. Saunders. Pages 265-266.

39 East 39th Street

Virus-Cancer Research

The role of viruses in cancer are described in a 20-page booklet, "Virus-Cancer Research," issued for the general public by the U.S. Department of Health, Education, and Welfare. It was prepared by the National Cancer Institute. This text explains some of the approaches utilized in virus-cancer work. It discusses the nature of viruses, their existence in our modern environment, and their implication in leukemias, lymphomas and solid tumors. The pamphlet also describes efforts to find a possible virus-cancer path from animals to man, and reports on the prospects for prevention and therapy of viral diseases.

Viruses are responsible for such a variety of cancer in laboratory animals that it would be surprising if they did not cause some type of cancer in man. By making use of tissue culture, electron microscopy, and many other sophisticated laboratory methods, researchers hope to come up with answers to the questions posed by this evidence. If a virus-cancer link in humans can be demonstrated, it may pave the way for the development of new preventive measures and may open up new areas in the treatment of cancer.

Single copies of the pamphlet, "Virus-Cancer Research" (NIH Publication No. 29) are available without charge from the U.S. Department of Health, Education, and Welfare, Washington, D.C. 20402. It may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 at 20 cents per copy.

An orthopedist can practice a long time without seeing a case of Lisfranc Dislocation. Here is a run down on this uncommon disorder.

Lisfranc Dislocations*

Daniel J. O'Regan, M.D./Jersey City

The literature on the subject of tarsometatarsal dislocations raises more questions than it answers, for example:

1. Did Lisfranc actually describe the injury? Watson-Jones[1] says that he did, stating that: "Tarsometatarsal dislocation was hallowed at Waterloo." But Cassebaum[2] insists that Lisfranc never wrote on the subject. He says that the name derives from the site chosen by Lisfranc for the amputation described by him when he was a surgeon in the armies of Napoleon.

2. Is it a common or rare injury? Aitken and Poulson[3] cite sixteen cases in fifteen years at the Boston City Hospital; Jeffreys[4] says it is uncommon. Cassebaum[2] finds that no author has reported more than nine of his own cases. Patterson (discussing the paper of Aitken and Poulson[3]) could find only five cases at the New York Hospital and the Hospital for Special Surgery. He cites P. D. Wilson, Senior, as having seen only one case in his extensive private practice. In contrast, Del Sel,[5] of Argentina, recorded thirteen cases in eighteen months, occurring in farmers and among the mounted forces.

Apparently, it was more common when the horse was the usual means of travel, as Bassett[6] reports. Being dragged by a horse with the foot caught in a stirrup was a prime mode of injury. The transition from horseback to the automobile has reduced the incidence of this accident.

3. Is it an unusually dangerous injury because of arterial damage? Gissane[7] is emphatic in warning us. He describes three cases, all of which required below knee amputations. Most others consider the vascular dangers as infrequent.

Cassebaum[2] sums up the available information in the clearest manner. These cases can be severe when there is direct forceful trauma to the tarsometatarsal area, as when an automobile wheel runs over the foot. Severe soft tissue damage may then occur. Today, most cases are the result of indirect stress, such as a fall downstairs or stepping off a curb. Injuries like these are not ordinarily associated with arterial damage.

When arterial damage does occur, it is usually due to a rupture of the terminal portion of the dorsalis pedis artery as it enters the plantar arch between the first and second metatarsal bases. Another finding has been spasm in the posterior tibial artery behind the medial malleolus. Both of these lesions were described by Gissane.[7]

Possible mechanisms and classifications of injury are described by several authors. The most useful is the classification *direct* or *indirect*. In the former, a forcible thrust against the dorsum of the foot may force the metatarsal bases plantarwards. The indirect, which is more common, combines rotational forces with tightening of the strong plantar soft tissues, pushing the metatarsal bases dorsally and lateralwards.

The displacement may be *uniform*, where all the metatarsals shift in the same direction, or *divergent*, with the first metatarsal moving medially, away from the others. The deformity may involve one or all of the metatarsals, or any combination. Fractures are usually

* Read before the Section on Orthopedic Surgery, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969

associated with the dislocation. Granberry and Lipscomb[5] reviewed 25 cases at the Mayo Clinic (without giving the time interval); only eight of these had dislocations without significant fractures.

Treatment varies in details, but accurate reduction plus stabilization with Kirschner wires was commonly advocated. The Mayo review[8] stated that eleven of 25 cases eventually required arthrodesis, and they proposed that all patients needing open reduction also have a primary arthrodesis.

The key to reduction is the stability of the base of the second metatarsal, which has been described as the keystone of the area. If the reduction can be obtained manually, open reduction is not required. If the second metatarsal remains displaced, an operation must be performed. Whether reduction is accomplished by open or closed methods, fixation with two or more wires or pins is advisable to maintain stability. Accuracy in reduction is important, although minor residual displacements are not incompatible with good function.

Case Report

This search of the literature was stimulated by an injury sustained by a 41 year old man who had been playing touch football on July 4, 1968. He stumbled while running, and thought that he had "turned his right foot" under him. There was severe pain and he was unable to stand on the foot. He was seen at another hospital, and was transferred to St. Francis Hospital in Jersey City on the date of injury. X-rays taken through a protective cast showed a dorsolateral dislocation of all the metatarsal bases, without any fractures. Color and temperature of the toes were normal. On removal of the cast, under anesthesia, the deformity was visible and palpable. There was mild edema, but no sign of impairment of the blood supply.

The foot was suspended with counter-traction for several minutes. Closed manipulation was then tried. There was improvement in the first tarsometatarsal joint, but the second remained displaced. Further manipulation with a Kirschner wire through the metatarsals for better traction did not change the position. Therefore, a curved transverse incision was made over the metatarsal bases. There was no unusual bleeding. The anterior tibial tendon was not displaced between the first and second metatarsals, as has been described, and there were no fractures other than a few small spicules of bone off the base of the second metatarsal, which was displaced dorsally atop the third cuneiform.

As soon as the second metatarsal had been pried off the cuneiform, it slid easily into its normal position, and the rest of the forefoot could be properly aligned. The reduction was unstable, and it was held by two Kirschner wires passed at different angles, and allowed to protrude through a short leg circular cast, which was immediately split.

There were no unusual problems following surgery. Vascularity remained normal, and the patient was discharged eight days after operation, with instructions not to bear weight on the right foot.



Figure 1 — Anteroposterior view of tarsometatarsal dislocation.



Figure 2 — Lateral view of tarsometatarsal dislocation.

Readmission was ten weeks after surgery. When the cast and wires had been removed, the foot was stable, and x-rays showed no change in position. Circulation continued to be normal. Dorsiflexion was weak in early physiotherapy, and a Klenzak brace was ordered. He was allowed to walk, at first with crutches and then a cane. There was moderate discomfort, but no more than following other foot surgery or injuries. He resumed his work as a salesman in mid-October, fifteen weeks after injury.

Dorsiflexor strength responded slowly and steadily; the brace was discarded in December. The last examination was in March of 1969. The patient is on all his usual activities, wearing standard oxford shoes. Gait is without limp, and he has only occasional mild discomfort in the foot. He can walk on his toes and heels without difficulty.

This case represents a dorsolateral dislocation without significant fracture, as a result of in-

direct trauma. Closed reduction was hindered by the failure to mobilize the second metatarsal. Once this had been accomplished by open means, there was no problem in obtaining satisfactory position. Immobilization was with two wires incorporated in a cast; it might have been discontinued sooner than the ten weeks. Extra caution was used in this case. At no time was there any danger to the blood supply of the foot. Functional result and appearance of the foot eight months after surgery remain good.



Figure 3—AP and oblique views three months after reduction.



Figure 4—Lateral view three months after reduction.

Summary

1. Tarsometatarsal dislocations are uncommon, but not rare.

2. Dorsolateral displacement of the metatarsals due to indirect trauma is the common mechanism of injury.

3. The displacement of the second metatarsal is the key to the ease or difficulty of the reduction. One should not hesitate to use open surgery, and fixation with two or more wires or pins is advisable.

4. The vascular status of the foot must be carefully observed, but arterial damage or insufficiency is not a common problem.

5. The case presented is the only one encountered in fourteen years of the author's private practice of orthopedic surgery.

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149 Kensington Avenue

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

The occasional association of erythrocytosis with large fibroids is here reported but not explained. Hysterectomy cured the erythrocytosis

Erythrocytosis Associated With Uterine Fibroids*

Richard J. Kline, M.D./Livingston; Joseph J. Pratt, M.D.; and David G. Hanlon, M.D./ Rochester, Minnesota

Thomson and Marson,[14] 1953, were the first to describe the remission of erythrocytosis in a patient from whom they had removed uterine fibroids. Since then, seventeen cases have been described in the literature.[1,3,5,10,12,16] In all patients the myomas have been large. No associated elevation of white blood cells or platelets has been present. Polycythemia vera has been excluded; and removal of the fibroids resulted in a return to normal of erythrocyte concentrations.

A review of the files of the Mayo Clinic between 1945 and 1965 revealed only three cases in which polycythemia was apparently associated with large uterine fibroids and in which the polycythemia disappeared when the fibroids were removed. These represent the incidence in 5,000 patients who received surgery for uterine fibroids during that time.

Case 1

A married 66-year-old housewife weighed 200 pounds. She was admitted to the Mayo Clinic on October 5, 1962. She had noticed swelling of the legs, increased body hair, and a feeling of fullness in the stomach during the previous 3 years. Some increases of facial hair, and a male escutcheon were noted. A 12-by-24-inch lobulated, freely movable, pelvic tumor was palpated.

Results of laboratory examination of the blood are in the table. Blood pressure was 160/90. Pulse was 80. Blood and urine steroids were suppressed by dexamethasone. A stimulation of body gonadotropin and estrogen by intravenously administered human gonadotropin was attempted. All results were within the normal range of values. Roentgenologic findings of the skull were normal, but a scout film of the abdomen showed a soft-tissue mass arising from the pelvis.

Exploratory laparotomy confirmed the presence of uterine fibromyomata. A total abdominal hysterectomy and left salpingo-oopherectomy were done. The ten pound uterus contained multiple calcified uterine myomas. Blood loss was minimal.

The postoperative course was uneventful, and result of a suppression test with dexamethasone was again within normal limits.

Case 2

A 60-year-old, married woman weighing 232 pounds was admitted to the Mayo Clinic on October 17, 1955. For more than ten years she had complained of stomach pains aggravated by nervousness and fatigue. A large, firm, nontender mass was felt in the lower abdomen and pelvis. Laboratory results are presented in the table. Blood pressure was 145/92. Pulse was only 64. A scout film of the abdomen and a roentgenologic examination of the upper part of the gastrointestinal tract and colon (with contrast material) demonstrated a soft-tissue mass filling the abdomen to the level of the first lumbar vertebra. Laparotomy confirmed the presence of uterine fibromas. Total hysterectomy, bilateral salpingo-oopherectomy, and appendectomy were done. Blood loss was minimal. The uterus was found to contain multiple fibroids.

The results of hematologic examination of the blood done two months after surgery are within the normal range (Table).

Case 3

A 59-year-old married woman, weighing 127 pounds, was admitted to the Mayo Clinic on October 15, 1945. She had had an abdominal tumor for ten years, diagnosed as a uterine fibroma.

On examination there was found a "term-sized" lobulated mass arising from the pelvis. Laboratory results appear in the table. Blood pressure was 164/94. Pulse was 80.

Because of polycythemia, five venesections of 500 milliliters each were performed. At laparotomy the presence of uterine fibromas was confirmed. Subtotal hysterectomy and bilateral salpingo-oopherectomy were done. The uterus and fibroids weighed almost 15 pounds.

Postoperative course was uneventful. On discharge, she received one intravenous injection of radioactive phosphorus. When the patient was last seen, ten years postoperatively in 1955, her blood values were normal.

* This work is originally from the Mayo Clinic, Section of Surgery (Dr. Pratt) and Section of Medicine (Dr. Hanlon), and from the St. Barnabas Medical Center in Livingston.

The association of uterine fibroids and erythrocytosis is rare. Vanden Berg and Vasu[15] reviewed the records of 790 patients who underwent hysterectomy for uterine fibroids at Butterworth Hospital and found not one associated with erythrocytosis.

When erythrocytosis is present with uterine fibroids, it is the only abnormality found. No reports of elevated leukocyte or platelet count (as seen in polycythemia vera) have ever been substantiated. Not one of the signs and symptoms characteristic of polycythemia is present, such as cyanosis, splenomegaly, hepatomegaly, or visual difficulties. Commonly, the patients have symptoms other than those attributed to the polycythemia. The polycythemia is discovered only on routine laboratory examination. None of our patients had hematologic symptoms, and only one (Case 1) had symptoms attributable to the tumor, that is, bloating, fullness, and peripheral edema. The patients reported in the literature were of low parity and were either just premenopausal or just postmenopausal. All three of our patients were postmenospausal.

The paucity of reports has hindered the investigation into the cause of the association between uterine fibroids and erythrocytosis. Horwitz and McKelway[8] noticed sinusoidal vascular spaces on histologic examination of the myomas and suggested that these spaces might function as arteriovenous shunts. Fleming and Markley[6] were unable to demonstrate such spaces and pointed out that the peripheral location of the shunt would tend to increase the total blood volume, rather than cause the isolated increase in red cell mass seen in secondary polycythemia. Babuna and associates[2] have suggested the liberation of an erythropoietic factor from the tumor that could produce polycythemia by directly stimulating the bone marrow, prolonging the life span of the erythrocyte, or inhibiting the reservoir function of the spleen, thus releasing large quantities of erythrocytes into the circulation. Cohen and Rothenberg[3] suggested that the mechanical pressure caused vascular embarrassment to the pelvic bone with consequent marrow hypoxia and release of an erythropoietic factor.

Aboulafia and co-workers[1] thought that the tumor, by mechanical interference with the kidney and ureters, stimulated the production of erythropoietin. Rothman and Rennard[12] suggested that the tumor may compress renal vessels, impairing the circulation to the kidney, which might have an effect on the kidney erythropoietic factor similar to that found in non-neoplastic renal disease. They believed that such a possibility is consistent with the observation that polycythemia has been found only in association with large myomas. The weights of the surgical specimens, both in the cases presented herein and in those found in the literature, have been from 4½ pounds to 18½ pounds with an average weight of 11½ pounds. Vanden Berg and Vasu[15] proposed that, because of the large size of these tumors, pulmonary ventilation may be interferred with and mild hypoxia may result. In two patients (Cases 1 and 2) the tumor may have contributed to the compromise of ventilation that was already present because of extreme obesity. The first patient weighed 200 pounds and the second 232. The third patient weighed only 127 but (in relation to her body weight) had the largest tumor, 15 pounds. This was 12 per cent of her total body weight. In speculating a mechanical cause, it is interesting that no reported cases of large ovarian cysts associated with erythrocytosis could be found in the literature. One of our patients (Case 1) had symptoms similar to those in a mixed type of Cushing syndrome; that is, edema, increased facial hair, and a male escutcheon. However, results of suppression tests with dexamethasone (before and after the operation) were within the normal range of response. No evidence of adrenal or ovarian tumor was present at operation. In our three cases, no other obvious cause of the polycythemia, such as cerebellar or midbrain tumors, non-neoplastic renal disease, or benign or malignant renal tumors, was present.

The mechanism of the erythrocytosis in hypoxia probably is the stimulation of bone-marrow production by erythropoietin. The main source of the erythropoietin is considered to be the kidney, although Osnes[11] stated the belief that the liver also may contribute

HEMATOLOGIC DATA ON THREE PATIENTS WITH ERYTHROCYTOSIS ASSOCIATED WITH UTERINE FIBROIDS

Case	Age, yr	Date	Event	Erythrocytes, million/cu mm	Hematocrit, %	Hemoglobin, gm/100 ml	Leukocytes, 1,000/cu mm	Platelets, per cu mm	Blood volume, Whole blood	ml/kg Plasma
1	66	10–5–62	Admission	5.93		17.7	7.8	244,000		
		10–17–62	Celiotomy							
		10–26–62	Dismissal			15.5				
		9–2–65	Follow-up			14.9				
2	60	10–17–55	Admission	6.09	62	17.1	6.9			
		11–14–55	Celiotomy							
		11–19–55	Postop.	5.35	50	14.3	3.6			
		1–20–56	Follow-up	4.87		14.3	6.8		64	33
3	59	10–15–45	Admission	6.59	79	20.4	6.3	221,000	115	34
		10–25–45	Venesection	4.09	45					
		11–2–45	Celiotomy							
		11–3–45	Postop.	3.64	33	8.6	17.5			
		11–11–45	Dismissal	4.2	35	11.9				
		3–15–48	Follow-up	4.6	46	13.6	8.6		59	32
		4–10–55	Follow-up	4.89		13.2	11.2			

to the production of erythropoietin or erythropoietin-like substance. Erythropoietin assays have been done[2,14] on both serum and extracts of tumor tissue from patients with uterine fibromas and erythrocytosis but, as yet, no erythropoietin activity has been demonstrated.[11]

It is characteristic in the association of erythrocytosis with uterine myomas that the removal of the myomas results in a cure of the erythrocytosis. All three of our patients had complete remission although one patient (Case 3) received an intravenous dose of radioactive phosphorus before discharge. In retrospect, it would seem that the radioactive phosphorus was not necessary. On the basis of reported cases, one would expect that all the remissions would be permanent. Yet Damon and Holub[4] have reported a case in which the erythrocytosis disappeared after the uterine fibroids were removed, but in which polycythemia vera developed five years later.

Summary

Three cases of erythrocytosis associated with large uterine fibroids are presented in which cure was obtained by removal of the fibromas. There is a relationship between the erythrocytosis and the uterine fibroids which may involve the erythropoietic system, but the exact mechanism has not yet been worked out.

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65 East Northfield Avenue

Meticulous history-taking is still the hallmark of the good clinician. Here are some examples.

The Cardiologist As A Clinical Historian

Bernard B. Eichler, M.D./Montclair

Perhaps the time may come when a patient with suspected heart disease will be exposed to a computer and, after some whirring of dials, the diagnosis and treatment of the disease will be immediately available. Or, perhaps, our suspect will be led into a room where instant cardiac catheterization, phonocardiography, angiography, electrocardiography, and exercise tests can be instantly carried out. However, until all this happens, the diagnosis and treatment of the patient with heart disease will remain principally the problems of the internist and cardiologist, who, as he has for many years, should be able to continue to care for most of his patients with a minimum number of gadgets. The availability of gadgets leads some of us to forget or ignore some of the finer delicacies of accurate diagnosis and successful therapy. Indeed the technic of history-taking has become a neglected art. I have been disturbed more and more recently by the problems in management that have arisen because of lack of historical detail. Here are some typical incidents.

A patient with rheumatic heart disease was hospitalized with his first episode of severe acute left ventricular failure. Therapy with digitalis and diuretics, prescribed by his physician, was strictly adhered to. However, questioning him about salt intake revealed that he had never been told about a low salt diet. This one facet of therapy seems to be a common omission since the appearance of the oral diuretics. With careful adherence to a low salt regime and with the same drug therapy, the patient has remained free of any evidence of failure.

Another instance of careful interrogation illustrates the value of this phase of management. A patient with persistent heart failure insisted that he took his medication as prescribed and rigidly followed his "low salt" diet by not using any salt. Questioning him specifically about his individual meals revealed that he ate the same lunch every day for years, a large portion of pickled herring! This dietary idiosyncrasy in an old New England son of the American Revolution was startling, but a change in lunch promptly cleared his heart failure.

Although chest pain promptly suggests the possibility of heart disease, pain in other areas seems too often not to arouse the suspicion. A patient telephoned from a distant city to say that, after returning to his hotel room, he had begun to have an annoying pain in his left elbow. The hotel physician suggested that he had "arthritis" from eating and drinking too much at dinner. Questioning revealed that some sweating was present and almost imperceptible breathlessness. He was strongly advised immediately to seek the help of an internist. The diagnosis of acute myocardial infarction was verified promptly. It might be appropriate to recall that pain of cardiac origin may appear localized in the arms, shoulders, back, jaw or upper abdomen without any concomitant chest pain. A few pertinent questions would help to arouse the suspicion of a cardiac etiology.

A patient with a history of coronary artery disease and chronic anticoagulant therapy

suddenly began to have purpura and gross blood in the urine and stools. Prothrombin time was markedly elevated despite the patient's insistance that there had been no change in his Dicoumarol® dosage. Questioning revealed that he but recently had been started on Clofibrate® because of "high cholesterol." Neither the patient nor his physician were aware that this drug prolongs the prothrombin time in patients receiving prothrombin-depressant medication.

Other subtle bits of information obtained only by meticulous history-taking should arouse suspicion. The patient who suddenly gains some weight despite "eating so little" suggests early fluid retention. Similarly, insomnia in one who previously had slept well should provoke the thought of impending nocturnal dyspnea. The "social drinker" too often when pressed for details, will often admit to excessive intake.

The electrocardiograph, too, can be a most deceptive bit of machinery. One patient, at the age of 46, was found to have inverted T waves in leads I, II and the left V, during a routine physical workup. So, instead of going to North Carolina on a golfing vacation, he disgustedly went to the hospital for four weeks with a diagnosis of coronary artery disease. T waves remained inverted on discharge and were still inverted two years later when a large hiatus hernia was found. Twenty years later, the T waves were still unchanged and the patient plays eighteen holes of golf without any symptoms. The moral: an inverted T does not always a coronary make.

The family history may also be highly suggestive. The tendency for diabetes mellitus, gout, hyperthyroidism, coronary artery disease to recur in families is significant and the appearance of any of these in a patient's ancestors should at least arouse the suspicions of its presence in a patient.

The internist of a generation ago became of necessity an excellent historian and his ability to extract detailed information from a patient would do credit to an expert trial lawyer. I am afraid that, with the appearance of exotic and sophisticated machines and technics, we are more and more neglecting the extremely valuable ability to learn by asking.

76 Union St.

Chart On Athletic Injuries

You can now get an AMA-sponsored *First Aid Chart for Athletic Injuries.* Printed on 11 by 17 inch stock, this is intended for posting in recreation areas and locker rooms. It outlines in simple terms the emergency treatments for bone injuries, open wounds, heat illness, impact blows, muscle and ligament strains, blisters, burns, and eye injuries. It also alerts the reader to look for the Emergency Medical ID Symbol and carries space for writing in local emergency phone numbers.

A likely companion to the first aid chart is the poster, "The Bill of Rights for the School and College Athlete," in the same size and stock. Here is shown, the athlete's entitlement to good coaching, good officiating, good equipment, facilities, and good health supervision.

Both the first aid chart and the "Rights" poster may be encased in weatherproof laminated plastic @ $3; non-laminated heavy paper stock, singles @ 30 cents, ranging up to 1,000 @ 20 cents. Orders in quantity for the chart should be coded OP-307 and for the "Rights" OP-37 and sent to the AMA Order Department. The address of course is 535 North Dearborn Street, Chicago 60610.

NEW JERSEY DOCTORS' NOTEBOOK

Diabetes Week November 16 to 22

The life span of the American population is increasing every year, and if we live long enough almost everyone of us may develop diabetes. As guardians of health of the public, we should detect diabetics as early as possible, put the patient on a diet, and arrange for all other corrective measures, including oral hypoglycemic preparations.

Diabetes is a familial disease and *any* member of the family of a diabetic, particularly over the age of 40 and/or obese, should be checked periodically. Do *not* rely on fasting blood sugars because you will miss the mild cases which frequently show a normal blood sugar level. Order the blood sugar two hours *after* a meal which contains a fair amount of carbohydrates. In that way you will pick up many diabetics at the height of metabolic activity.

It is easier to control a diabetic at an early stage of the disease than later on when the symptoms are full blown, and the patient may have developed complications. Even young, insulin-sensitive diabetics may, in the initial stages, be controlled by oral agents, and thus we may hope to postpone or maybe even prevent serious after-effects.

The American Diabetes Association reminds us every year in November, to look for and discover the early diabetics; however, the search should be a constant one all year around. Now is the time that Chairmen of the local Diabetes Detection Drives distribute, to the general public, pertinent facts by radio announcements, television, and newspaper releases, in order to encourage the public to see their family physician for an examination. The wisdom of stressing prevention of the disease rather than treatment is obvious. We doctors should always be in the forefront of this movement.

Extended Care Facilities Covered By Medicare

(This HEW release is supplied by the Prudential Insurance Company, official intermediary for the Medicare Program, for the guidance of our members.)

To assure prompt and equitable determinations as to whether care furnished to patients in extended care facilities is covered and can be paid for under Medicare, the understanding and cooperation of physicians, hospitals, ECFs, utilization review committees, intermediaries, and carriers are vital. We hope this message will help to achieve these objectives.

(a) *What is "extended care?"* The covered level of care provided when the patient's condition upon his discharge from a hospital requires him to be in an institution for the *primary* purpose of receiving continuous skilled nursing services and other professional services.

(b) *What are "skilled services?"* A skilled service is one which *must* be furnished by or under the supervision of trained medical or paramedical personnel. A service is not skilled merely because it is performed by a trained medical or paramedical person. A service which can be safely and adequately self-administered or performed by the average, nonmedical person, without the direct supervision of trained medical or paramedical personnel, is a non-skilled service without regard to who actually provides the service.

(c) *What is "noncovered care?" Any* level of care less intensive than extended care. Formerly, all noncovered care was referred to as "custodial care."

(d) *What are the responsibilities of the attending physician and hospital?* The attending physcian customarily plans in advance for the needs of his patient including, where appropriate, transfer from a hospital into an ex-

tended care facility. The hospital can and should aid in this planning process. Following is the preferred approach:

1. While the patient is in the hospital, a medical information summary should be prepared including the physician's orders for the patient's care in the facility, a profile of the patient's condition, and the services expected to be needed.

2. This summary should be submitted by the hospital to the facility prior to the time of the transfer of the patient.

3. If the summary is to be incorporated into a form, it may be incorporated into a standard form agreed to by the intermediary and the providers of service.

When this information has not been submitted in advance as indicated above, alternate approaches should be used to supply the needed information. We have been advised by the medical profession that good patient care requires the extended care facility to have available by the time of admission, in writing, the required patient care information. The written data may in some instances be preceded by telephone orders which would make possble advance preparations for care.

(e) *What procedures should extended care facilities follow?* If adequate information is received, requiring it to furnish skilled services which are obviously covered care, no special action need be taken by the ECF. However, if the ECF thinks there could be reasonable doubt upon admission that the care is covered (or if, during the ECF stay, there is a significant change in the level of care), it should take these steps:

1. Complete a "medical information form" or equivalent (by the ECF's director of nursing services, the charge nurse, or a physician) based on the attending physician's orders and the transfer hospital's medical information. A copy of the hospital's information summary or the attending physician's orders would generally be an acceptable substitute.

2. Forward this medical information to the intermediary within 48 hours of admission or when a change in the level of care raises doubts as to coverage.

3. The utilization review committee should review promptly each admission where there is a question of whether the required level of care is covered to help screen out claims for care which are obviously noncovered.

4. To minimize the need for recontact by the intermediary, the utilization review committee should record the skilled services it considers to justify extended care on a medical information or other form, and the information should be included with any submission of utilization review committee findings by the extended care facility to the intermediary.

(f) *What actions will the intermediary take in its determinations?*

1. Process medical information forms promptly and inform the ECF of the results.

2. Where the care is deemed covered, reimburse the ECF as long as the patient requires that level of care, up to the maximum benefits.

3. Where the ECF is conscientiously carrying out the procedures listed above in each questionable case, the intermediary will presume that *a case with unclear evidence is covered up to the time when the ECF is advised that additional evidence and evaluation by the utilization review committee is required.* However, if the ECF has not been following the recommended procedure for questionable cases described above in (e), retroactive denial may be made back to the date of admission or any subsequent date established by the evidence.

204th Annual Meeting
May 16-19, 1970
Atlantic City

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—Richard Helfant, M.D., Peter Bent Brigham Hospital, Boston, Massachusetts 02115. NYU Bellevue 1963. Board eligible. Cardiac catherization laboratory in hospital. Available July, 1970.

DERMATOLOGY—Charles Wasilewski, Jr., M.D., 205 Oak Street, Danville, Pennsylvania 17821. Jefferson, 1963. Board eligible. Multispecialty group. Available July 1969.

Frederic R. Rothman, M.D., Q 845, Christy Court, Naval Air Station, Pensacola, Florida 32508. Michigan, 1964. Board eligible. Partnership or group. Available July 1970.

INTERNAL MEDICINE—Chaim Charytan, M.D., 109 Eastridge Drive, San Antonio, Texas 78227. Einstein College of Medicine, 1964. Board eligible. Subspecialty, nephrology. Solo, partnership, group, or institution. Available July 1970.

Noel I. Robin, M.D., 19 Lake Shore Court, Brighton, Massachusetts 02135. Downstate Medical Center (NYU), 1965. Board eligible. Subspecialty, endocrinology. Group (teaching hospital and medical school affiliation). Available July 1970.

OBSTETRICS AND GYNECOLOGY—Louis V. Miller, M.D., 353 Rolling Hill Road, Elkins Park, Pennsylvania 19117. Ohio State, 1959. Board eligible. Group or partnership. Available July 1969.

Stan P. Smith, M.D., 3702A Spruce Street, Dover, Delaware 19901. Temple, 1964. Board eligible. Partnership. Available September 1970.

PEDIATRICS—Franz Hummert, M.D., 58 Pine Grove Terrace, Newark 07106. Muenster, West Germany 1961. Board eligible. Group or partnership. Available November 1969.

Deborah Chernock (Block), M.D., 536 Wyndham Road, Teaneck, New Jersey 07666. University of Chicago, 1966. Associate or group. Available.

SURGERY—Malcolm H. Sawyer, M.D., HQ. 3rd Air Force, Box 1563, APO New York 09125. Northwestern, 1936. Board eligible. Industrial or administrative. Available September, 1969.

Warren X. Collmann, M.D., 77 Penn Drive, West Chester, Pennsylvania 19380. University of Pennsylvania, 1950. Board certified. Group, partnership, or solo. Available.

Pun Fai Yuen, M.D., 113 USPH Hospital, Lawton Oklahoma 73501. St. Louis University School of Medicine 1960. Board eligible. Group. Available October 1969.

Francis M. Bohan, M.D., 229 Dickman Drive, Lunestone, Maine 04750. Cornell 1963. Board eligible. Associate or group. Available July 1970.

Ali Ghazi, M.D., 195 Adams Street, Brooklyn, New York 11201. University of Teheran 1958. Board eligible. Associate or group. Available.

Ignacio M. Cruz, M.D., 1038 58th Street (Woodside) New York, New York 11377. University of Santo Tomas, 1959. Board certified. Group, partnership, or full time. Available.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during August 1969.

	August 1969	*August 1968*
Aseptic Meningitis	12	72
Primary Encephalitis	2	7
Post-Infectious Encephalitis	0	1
Hepatits, Total	197	161
Infectious	161	127
Serum	33	34
Malaria	22	10
Military	19	4
Civilian	3	6
Meningococcal Meningitis	4	4
Military	1	0
Civilian	3	0
German Measles	13	2
Measles	32	26
Salmonella	45	70
Shigella	15	16
Mumps	19	28

Tuberculosis

Modern drugs have revolutionized the management of tuberculosis from the standpoint of hospital treatment, home care, preventive therapy, and public health. The need for hospital care has been reduced and in many instances eliminated by effective therapeutic regimens that produce more rapid cures and interrupt the communicability of the patient's disease even though organisms still may be excreted. Preventive therapy administered to family and household associates of cases, even before the tuberculin test becomes positive, minimizes chances of tuberculosis in these individuals.

The general hospital can now safely and effectively treat tuberculosis patients who need hospitalization, utilizing anti-tuberculosis drugs and modern infection control methods. The greatest hospital and community risk is the unrecognized case. The use of the general hospital for tuberculosis patients is recommended by the U.S. Public Service, the American Thoracic Society, and the National Tuberculosis Association.

New *Rules and Recommendations for Tuberculin Testing* developed by the State Department of Health and the State Department of Education for tuberculosis surveys in New Jersey schools specify that an intradermal tuberculin test (as the initial means of screening) will be given to all pupils of the 1st, 5th, 9th and 12th grades, post-graduates, special education categories, new admissions, and all full time and part-time employees.

An important consideration for the family physician is that the tuberculin test identifies persons who have had a tuberculosis infection in order that they may be evaluated for disease, treatment, and preventive therapy with isoniazid. The positive tuberculin test also indicates that the reactor has been exposed to a possible source of tuberculosis. In this respect, examination of family, household, and close associates of reactors can uncover potential sources of infection. Local health authorities are interested in arranging for the examination of these associates.

Preventive treatment for reactors is recommended by the U.S. Public Health Service since chemoprophylaxis can reduce future morbidity from tuberculosis 50 to 75 per cent. Extensive chemoprophylaxis in tuberculin school reactors, household contacts of a case, and other high risk individuals would probably reduce by 300,000 the number of cases in the U.S.A. in the next 15 years. The recommended dose of isoniazid for chemoprophylaxis is 300 milligrams per day for adults and 10 milligrams per kilogram of body weight per day for children, not to exceed 300 milligrams per day, to be administered in a single daily dose for twelve months.

The Senior Center's Clinic

A survey showed that a high ratio of the senior members of the Newark Day Center were living on an income consisting only of social security which in many cases averages $75 per month. Spurred on by this, the center opened a medical clinic for its members. This was done in October 1968. The staff consisted of a volunteer doctor and a Red Cross nutritionist, a technician, and a social worker. Many have been unable to afford Medicare because of the $50 deductible each year. This must be paid out of their meager incomes before they are reimbursed 80% of the cost of each visit. Hospital clinics are not free and the results have been a desperate lack of medical care for these people. The Executive Director of the Day Center writes as follows:

We have found many of them suffering from nutritional defects, not only from lack of essential foods, but also poor choice of foods. We found many cases of severe anemia. Also, there are vitamin deficiencies to be corrected. Many are greatly under-weight and require special programs for rebuilding body weight. Many were hyperglycemic. Now we set aside one day a week when we feed them a meal advocated by the Diabetic Association. Two hours later we take a blood test. Those who are positive see a nutritionist, who works out their dietary needs. Our social worker calls on Welfare for additional money to make it possible for these people to get what they need including insulin or oral diabetic tablets. Our nutritionist gives pointers on how to buy and prepare food.

We approached an ophthalmologist in Newark who gave tests for glaucoma and examined the fundi for hemorrhage and arteriosclerosis. He advised a number of them to go to the hospital clinic for treatment. This is a preventive program.

Our next problem was how to get money to pay for prescriptions. Drugs are expensive and prescriptions can cost up to $4 for one. All the good done in examining and prescribing

was lost because they could not afford such payments. Many refused to have Welfare approached for payment and preferred to maintain their independence and do without. To date we have interested a friend of the Center to pay for these drugs which we give our members at no cost to themselves. Unfortunately we can't expect private individuals to continue to give and we must turn to sources that can be continuing in their support of our work.

Many of our members are living on soup, bread, tea, and sweet buns. To assist in this problem we serve a well balanced meal daily. It consists of meat, vegetables, bread and butter, dessert, and a beverage. Those who are able to pay, are charged 50¢.

This Day Center for senior citizens is at 305 Halsey Street in Newark. Its physician staff includes Anna R. Shults, M.D., Sisina Greco, M.D., and J. Wallace Hurff, M.D. Ruth Clarke is the social worker and Wilma Allwoerden is the technician and nurse.

The Seven Pillars Of Sanity*

In a world seemingly gone mad with power, money, and political desperation, one wonders what has happened to sanity, and what actually keeps societies from collapsing. Fortunately, there are always a few plaintive voices crying in the wilderness.

Mankind must constantly make use of such constructive pillars as the following: Wisdom, Compassion, Understanding, Forgiveness, Simplicity, Patience, and Humor.

Wisdom cries its wares in the market place, and no one listens; for wisdom is the culmination of a lifetime of experience and contemplation-illumination. It is the "heavenly light for man."

Compassion is the distillate of human suffering, and the willingness to share the painful triumphs; the desire and hope for the individual's greatest potentialities in equality and opportunity.

Understanding is the tender thread weaving in and out of our years, supplementing what has already been learned to what needs to be learned about man and humanity. It is the "unlearning-learning" process-in-continuum, assuring us clarity and succinctness concerning human relationships and our own peculiar identities.

Forgiveness is the delicate bridge of communication that allows children and parents, husband and wife, neighbor and stranger, to live peacefully together, appreciating the similarities and differences that make the human family. Human balances and controls are precariously camouflaged in modern societies.

Simplicity is the essential needed for restoring order out of chaos, so that each human urge and desire fulfill reasonable and equitable criteria for accomplishment without expansive rhetoric.

Patience is that rare quality of achievement emerging from a long apprenticeship to humility, service, selflessness, and sincere altruism.

Humor, the last pillar, is the leavening talent that allows tragedy to be diluted, ignorance to be levitated, bitterness to be seasoned, vulgarity to be pivoted, and reality to be cushioned. It is the one pillar that finally makes the temple of sanity architecturally sound and subtly beautiful.

Man must not sit by indifferent or psychologically bewildered by events that seem beyond his comprehension and solution. Modern civilization is a deception-mirage that man is a thinking animal, aware of his responsibilities and ready to act judiciously. It is today a gross exaggeration, for most humans prefer the easy way of manipulating their lives, with minimum involvement in responsible management and lackadaisical laissez-faire mañanas.

* Reprinted from the March 1968 Journal of the Florida Medical Association.

Pascal, the great French philosopher-mathematician, saw man as ridiculous and grotesque, and elaborated upon his follies. Chekov, the great Russian writer, refused to teach or cure, knowing the frailties and foibles of the human race.

All of us, at times, become philosophers or poets in moments of anguish about the "human condition," pawns and victims of circumstances beyond our control. Often we reflect too lightly upon the pillars of sanity. Only master builders, visionary dreamers, optimistic realists, and impractical practicalists know what can be accomplished in their lifetime, and what must be done for future generations to bring about some semblance of unity and harmony before panic buttons put an end to all our strivings.

I. Leo Fishbein, M.D.
Miami Beach

Booklet On Drug Abuse

"In the final analysis, playing games with the truth has historically been demonstrated to be a mistake."

These are the words of the National Institute of Mental Health, speaking about the need to communicate honestly with young people on the use of drugs. This provides the basis for a 48-page book on drug abuse published by the National Association of Blue Shield Plans. It is offered free by our Blue Shield Plan.

Drug Abuse: The Chemical Cop-Out dispells romantic delusions of drugs. It separates the facts from the myths for both adults and young people. Indeed, parents are more lacking in knowledge about drugs than their teenagers. John Finlator, associate director of the Federal Bureau of Narcotics and Dangerous Drugs, says:

"There is one thing I think we are all missing the boat on. That is, we, who are in authority, find ourselves ignorant about the drug problem around us. The school teacher, the parent the school administrator, the businessman, and the housewife are all ignorant about the problem. Thus, when a young person starts talking about drugs, neither his parents nor his teachers are really able to keep up with him. If we are going to solve the drug problem, we must do so through an effective educational process, and one that can be accepted."

The four-color booklet features many photographs taken during the filming of three television specials on drug abuse being sponsored on television stations by local Blue Shield Plans. The three films are narrated by Robert Mitchum, Paul Newman, and Rod Steiger.

Chemical Cop-Out explains many of the physical and emotional effects of marijuana, the amphetamines, LSD, mescaline, and other drugs. It explores the sociologic and psychologic reasons for abusing drugs and how society is reacting to the use of chemicals as a means for escape. In the booklet, Robert Petersen, M.D. observes:

Parents are frightened, and you can certainly understand why. They tend to believe the notion that a joint of marijuana is the first step to becoming a hopeless junkie, or something of this sort, to the very realistic dangers of the kid getting arrested."

Dr. Alfred Freedman of the New York Medical College comments on one aspect of youth's involvement with drugs:

"It's not so much the physical dangers of drugs which do exist or that they will become criminally insane, which is ridiculous, but rather that they are developing an inward reality that is more meaningful to them than maintaining a concern with society in general. We are in very difficult times, and the participation of everyone, particularly the younger people, is extremely important. If the focus of their lives becomes centered upon drugs, we are losing something."

The booklet explores the distribution system of drugs including highly profitable heroin and the lucrative popular marijuana. A kilogram of marijuana, which starts out selling for $2, may wind up bringing as much as $500.

Methods for treating hard drug addicts are also explored. The work at research and therapeutic centers, including the federally-operated hospital in Lexington, Kentucky and Daytop Village in New York City are discussed.

Offered here is a realistic insight into the problem by authorities in the fields of law enforcement, medicine, and psychology. It is pointed out that society must take the initiative in seeking to change those factors in the environment which are conducive to using drugs as a means for escape.

The World's First Rubella Vaccine

A woman who contracts rubella during the first month of pregnancy faces a 50 to 90 per cent chance of giving birth to a grossly abnormal baby. This ratio decreases to about 10 per cent in the third month—still an unpleasantly high figure for any pregnant woman. Indeed, in the 1964-1965 rubella epidemic in the United States there were some 20,000 birth abnormalities or fetal deaths.

Since 1941, when the pregnancy hazards of German Measles were first revealed, there has been constant (but, until now, unsuccessful) efforts to develop a rubella vaccine. An organized scientific approach to this began in 1962 when scientists at Harvard and the Walter Reed Army Medical Center succeeded in isolating, identifying, and growing the rubella virus in laboratory tissue cultures. The Harvard researchers were Drs. Thomas H. Weller and Franklin A. Neva, and those at Walter Reed were Drs. Paul D. Parkman, Edward L. Buescher, and Malcolm S. Artenstein.

On April 3, 1969, Switzerland granted the first license in the world for a vaccine to prevent rubella to Recherche et Industrie Thérapeutiques (R.I.T.), a Belgian subsidiary of Smith, Kline and French. The license was granted for a vaccine using the live "Cendehill" virus strain. The "Cendehill" strain was developed by R.I.T. The vaccine, grown primarily in rabbit kidney cell cultures and manufactured at R.I.T. has been available for general use in Switzerland since spring. An application for license is being considered by the Division of Biologics Standards of the U.S. Public Health Service.

More than 60,000 persons throughout the world have been inoculated with the "Cendehill" vaccine during clinical trials which have demonstrated it to be safe and effective for all age groups. This strain was isolated in Belgium by Abel Prinzie, M.D., R.I.T.'s Director of Research and Development. The development of a vaccine started at the Biologics Department of R.I.T. in 1963 and has progressed under the direction of Constant A. Huygelen, D.V.M., Director of the Biologics Department, and Dr. Prinzie.

The vaccine has been tested in closed studies, family studies, and large-scale open studies in the Americas, Western Europe, the Caribbean, Asia, and Africa. Used largely in children, young girls, and adult women, it has caused no significant clinical symptoms and no significant adverse reactions. Arthralgia manifestation are minimal in the "high-risk" group of susceptible women.

The vaccine has achieved seroconversion rates averaging 97.5 per cent in large-scale open studies seven to nine weeks after vaccination. The vaccine is said to be safe for the environment and does not spread to susceptible subjects kept in close contact with the vaccine.

In addition to this rabbit kidney ("Cendehill") strain, the U.S Public Health Service is now considering another preparation grown in duck embryo or dog kidney cell culture systems. Tentatively identified as HPV-77, experimental vaccines produced in accordance with the standards have undergone extensive community testing in the United States and abroad. Two manufacturers, Merck, Sharpe and Dohme, and Philips Roxane Laboratories have produced vaccines based on this strain.

Dr. Robert A. Marston, National Institutes of Health Director said, "We hope that more than one vaccine will be available. Regulations covering the use of other virus strains and culture media for rubella vaccine production will be formulated on the basis of extensive tests now going on."

ANNOUNCEMENTS

Intensive Coronary Care

The Montclair Community Hospital announces a colloquium on the care of the patient in the intensive coronary unit. This seminar will be held from 4 to 6 p.m. on Wednesday, October 15 in the Conference Room of the hospital at 122 Harrison Avenue, Montclair. The program is approved for four hours by the AAGP. For further information, write to Dr. Milton Luria of 69 Fairview Avenue, Verona, New Jersey 07044.

Comparative Health: People And Animals

On Wednesday, October 15, 1969, the New Jersey Public Health Association (with the cosponsorship of The Medical Society of New Jersey) will hold its special program on "comparative behavior patterns in men and animals." The meeting will be at the Greenbrier Restaurant on U.S. Highway No. 1, just outside of New Brunswick. Dr. Arnold M. Kallen, Superintendent of the Essex County Overbrook Hospital, will preside at the morning meeting and Dr. Nicholas A. Bertha, President of The Medical Society of New Jersey, will moderate the afternoon session. An unusual program, with a star-studded faculty, has been provided. For more details and registration, write to Veterinary Public Health Program, Box 1540, Trenton, New Jersey 08625.

Seminar On Proctology

Starting on October 30, 1969, there will be a three-day conference at the Holiday Inn in Atlantic City on modern proctologic technics. The sponsoring agency is the Northeastern Proctological Conference, which includes the New Jersey Proctologic Society, the Pennsylvania Society of Colon and Rectal Surgeons, the New England Proctological Association, and the New York Society of Colonic Surgeons. Social, as well as scientific, sessions are planned. For details, write to Dr. I. G. Larkey, 1199 Clinton Avenue, Irvington, New Jersey 07111.

Clinical Application Of Basic Sciences

The November program of the Burlington County Memorial Hospital's series on clinical application of the basic sciences will cover endocrine problems on the 6th, hematologic problems in pregnancy on the 13th, and microsurgery of the ear on the 20th. The meetings are held at 3:30 p.m. in the T. J. Summey Building at the hospital. AAGP gives 1½ credits per session.

For registration and further information, please contact J. R. Wolgamot, M.D., Director of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Colloquium On Sexual Inadequacy

New Jersey physicians have an opportunity to hear the distinguished Masters and Johnson team by going to the Carrier Clinic at Belle Mead on Wednesday, November 5. The session opens at 1 p.m. and closes at 5 p.m. Topic of the day will be "Rapid Treatment of Sexual Inadequacy." Belle Mead is halfway between Princeton and Somerville, just off route 206.

Otolaryngology Seminar

A seminar in otolaryngology will be held on Wednesday, November 12, at the Robert Treat Hotel in Newark. The program, arranged by the New Jersey Academy of Ophthalmology and Otolaryngology, has been designed as a testimonial to George E. Shambaugh, Jr., M.D., professor of otolaryngology at Northwestern University School of Medicine in Chicago. It opens at 9 a.m. with a talk on the present status of laryngology by J. P. Atkins, M.D., chairman of bronchoesophology at the University of Pennsylvania. At 9:45 a.m., Dr. F. K. Hansel (professor of otolaryngology at Washington University, St. Louis) will speak on allergy in otology and laryngology. Dr. J. J. Conley of New York

will then discuss head and neck malignancies. The after-lunch program will be opened by J. H. Ogura, M.D., also of Washington University. Professor Ogura will discuss laryngeal transplants. The guest of honor, Dr. Shambaugh, will talk of the past and future of otology. A round table seminar will follow at 4:00 p.m. The social hour is set for 5:30 p.m. and dinner will start at 7 p.m. In the evening Dr. Shambaugh will address the group on "The Two Great Problems Facing The Practice Of medicine." For more details, write to Dr. Leon J. Schwartz at 162 Chestnut Street, Rutherford, New Jersey 07070.

Urologic Pathology

A course in urologic pathology — ideal for preparing for American Boards and useful for any urologist — is being offered by Columbia University for the ten-day period starting January 5, 1970. The program is held every Monday and Thursday from 3 to 6:30 p.m. Tuition is $150, and you must furnish your own microscope. For additional information, write to Associate Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 10032. Ask for the details about graduate course, *Urology-PM-1*.

Surgery Meetings Around The World

The American College of Surgeons has scheduled, in 1970, a January sectional meeting in Puerto Rico, and later in the same month one in Caracas and one in Panama City. Those interested in combining scientific programs with shipboard cruises and visits to foreign ports may get more details from the American College of Surgeons, 55 East Erie Street, Chicago 60611.

Learn While You Cruise

Albany Medical College announces that reservations are now being accepted for their eleventh medical seminar cruise starting on January 5, 1970. This is a seventeen day cruise from New York aboard the luxurious and distinguished *Gripsholm* of the Swedish American Line.

Ports of call include Virgin Islands, Martinique, Barbados, Trinidad, Venezuela, Netherlands Antilles, Dominican Republic, and Haiti. The faculty of Albany Medical College will present a comprehensive shipboard graduate program, covering subjects in medicine, surgery, pediatrics, obstetrics, and gynecology.

For more information, write to the Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

Chance To Study In Great Britain

A chance to study in Great Britain for three months is made available under traveling fellowship awards of the Royal Society of Medicine. A doctor who has had at least two years of research experience or specialized training will have an opportunity to work with colleagues in Great Britain. For more information, write to the Executive Director, The Royal Society of Medicine, 20 Broad Street, New York, New York 1005.

Radiologic Technicians Meet

The New Jersey Society of Radiologic Technologists will meet in Atlantic City on April 24 and 25, 1970. A program of graduate educational material has been provided, as well as seminars aimed at technologists who are seeking certification under the new State law. For more details, write to Marilyn Fay at 26 Wedgewood Drive, Verona, New Jersey 07044.

Ophthalmology: 1970

The New York Eye and Ear Infirmary will celebrate its 150th anniversary by an extensive and intensive colloquium on ophthalmology: 1970, during the week of May 6. Sessions will be devoted to cataract surgery, glaucoma management, eyeball motility, corneal cryosurgery, problems in the posterior segment, and surgery of the orbit. This clinical conference is sponsored by the Alumni Association of the Eye and Ear Infirmary. For further details, write to Gerald Pierce, M.D., Eye and Ear Infirmary, 310 East 14th Street, New York 10003, and mark your envelope "Clinical Conference."

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969

October

14 **Academy of Medicine of New Jersey**
Section on Dermatology and New Jersey Dermatological Society
Elizabeth General Hospital
Elizabeth
Skin Manifestations of Regional Ileitis and Ulcerative Colitis

15 **Academy of Medicine of New Jersey**
Robert Treat Hotel
Newark
Symposium: Organ Transplants

15 **Academy of Medicine of New Jersey and American Cancer Society**
St. Elizabeth Hospital
Elizabeth
Chemotherapy of Cancer

15 **Academy of Medicine of New Jersey**
Section on Urology
Marriott Motor Inn
Saddle Brook
Urology in Viet Nam

16 **Burlington County Memorial Hospital**
Mount Holly
The Differential Diagnosis of Jaundice

16 **Academy of Medicine of New Jersey**
Passaic General Hospital
Passaic
Pulmonary Problems and Inhalation Therapy

20-24 **Newark Beth Israel Medical Center and Academy of Medicine of New Jersey**
Newark Beth Israel Medical Center
Basic Vectorelectrocardiography

23 **Burlington County Memorial Hospital**
Mount Holly
Endocrine and Physiologic Sequelae of the Oral Contraceptives

23 **Academy of Medicine of New Jersey**
John E. Runnells Hospital
Berkeley Heights
Organization of Emergency Room Care

23 **Academy of Medicine of New Jersey, Section on Radiology, and New Jersey Radiological Society**
Academy of Medicine of New Jersey
Bloomfield
Interesting X-rays of the Month

25-26 **New Jersey Heart Association and New Jersey Regional Medical Program**
Atlantic City
Seminar on Coronary Care

29 **Academy of Medicine of New Jersey**
St. Elizabeth Hospital
Elizabeth
Hypnosis in Medicine

29 **Academy of Medicine of New Jersey**
Section on Pediatrics
Martland Hospital
Newark
Workshop on Cytogenetics

30 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar: The Role of the Pastor in Death

31 **Academy of Medicine of New Jersey and American Cancer Society**
Warren Hospital
Phillipsburg
Chemotherapy of Cancer

November

3 **Academy of Medicine of New Jersey and American Cancer Society**
Atlantic City Hospital
Atlantic City
Chemotherapy of Cancer

6 **Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Symposium: Infections Diseases

6 **Burlington County Memorial Hospital**
Mount Holly
Certain Gynecologic Disorders and Endocrine Management

12 **New Jersey Academy of Ophthalmology and Otolaryngology**
Robert Treat Hotel
Newark
Seminar on Otolaryngology

13 **Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Morristown Memorial Hospital
Symposium: Neuroblastoma in Children

13 **Burlington County Memorial Hospital**
Mount Holly
Hematologic Problems in Pregnancy

14 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Organization of Coronary Care Units

15 **St. Barnabas Medical Center**
Livingston
Clinical Applications of the Neural Sciences

19 **Academy of Medicine of New Jersey, Section on Radiology, and New Jersey Radiological Society**
Academy of Medicine of New Jersey
Bloomfield
Interesting X-rays of the Month

19 **New Jersey Chapter, American Academy of Pediatrics**
Holiday Inn
Kennilworth
Seminar on Pediatric Allergy

19 **New Jersey State Dental Society**
Semiannual Session

20 **Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
Hypnosis in Medicine

20 **Burlington County Memorial Hospital**
Mount Holly
Microsurgery of the Ear

25 **Hunterdon County Medical Society**

December

3 **Academy of Medicine of New Jersey**
St. Barnabas Hospital
Livingston
Symposium: Shock

3 **Academy of Medicine of New Jersey**
St. Elizabeth Hospital
Elizabeth
Organization of Emergency Room Care

4 **Burlington County Memorial Hospital**
Mount Holly
Parkinsonism: Assessment of New Therapeutic Modalities

8 **Academy of Medicine of New Jersey and American Cancer Society**
Paul Kimball Hospital
Lakewood
Chemotherapy of Cancer

9 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Workhop on Resuscitation

11 **Burlington County Memorial Hospital**
Mount Holly
Common Allergic Emergencies

18 **Burlington County Memorial Hospital**
Mount Holly
Crisis Counseling

1970

January

7 **Academy of Medicine of New Jersey**
Symposium: Immunology and Radiation Protection

8 **Burlington County Memorial Hospital**
Mount Holly
Newer Anesthetic Agents

15 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Medical Management of Gastrointestinal Hemorrhage

22 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Gastrointestinal Hemorrhage

27 **Hunterdon County Medical Society**

29 **Burlington County Memorial Hospital**
Mount Holly
Indications and Techniques for Urinary Diversionary Procedures

February

5 **Burlington County Memorial Hospital**
Mount Holly
Angiographic and Echographic Diagnosis of Genito-Urinary Lesions

11 **Academy of Medicine of New Jersey**
Symposium: "Isotopes and Recent Advances in Radiologic Diagnosis"

12 **Burlington County Memorial Hospital**
Mount Holly
Management of Chronic Renal Insufficiency

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Techniques

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

12 **Academy of Medicine of New Jersey**
Symposium: Pulmonary Embolism

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

24 **Hunterdon County Medical Society**

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

8 **Academy of Medicine of New Jersey**
Hoffman-LaRoche
Nutley
Symposium: "Surgical Management of the Mind"

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-20 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

OBITUARIES

Dr. Hugh M. Babbitt

Hugh M. Babbitt, M.D., a well known Union County orthopedic surgeon died on August 19, 1969. Dr. Babbitt was a 1929 graduate of the medical school of New York University. He was on the active or consulting staffs of the Somerset Hospital in Somerville, the John E. Runnels Hospital in Berkeley Heights, and the Muhlenberg Hospital in Plainfield. Dr. Babbitt had been serving the people of the Plainfield-Somerville area for 30 years. He was 66 at the time of his death.

Dr. Frank Bortone

One of our state's pioneers in thoracic surgery, Frank Bortone, M.D., died on August 10, 1969. Dr. Bortone was a 1912 graduate of the College of Physicians and Surgeons of Columbia University. He was an FACS, as well as a Fellow of the American College of Chest Physicians. He was certified both by the American Board of Surgery and the American Board of Thoracic Surgery. He was active in the affairs of our Hudson County Medical Society and in the Academy of Medicine of New Jersey. He was affiliated with both the Medical Center and the Christ Hospital in Jersey City. Dr. Bortone was 80 years old at the time of his death. During World War I, he was a medical officer in the Army of the United States and served with the AEF in France.

Dr. Wallace R. Bostwick

Possibly the only member of our Society to have been a member of the French Foreign Legion died on August 25, 1969. Born in 1898, Wallace Robert Bostwick received his M.D. at the medical school of Yale University in 1927. In 1916, at the tender age of 18 he went to France and offered his services as a Red Cross ambulance driver while World War I was raging across that country. A native of Montclair, he returned to that town after his interneship and did general practice there until 1935 when he moved to Blairstown. He was active in medical and civic affairs in Warren County, an elder of the Presbyterian Church, and an attending physician at the Newton Hospital.

Dr. John J. Danielson

On August 12, 1969, at the age of 64, John J. Danielson died after a short illness. He was an industrial physician who earned his M.D. at Georgetown in 1933. He served as a major in the medical corps of the United States from 1942 to 1946, and was on the surgical staff of the North Hudson Hospital in Weehawken. Dr. Danielson maintained an office for the private practice of medicine in North Bergen and did a good deal of committee work for the Hudson County component society. He was an active member of the Industrial Medical Association of our state.

Dr. Robert Glynn

At the tragically early age of 52, Robert Glynn, M.D., died on July 28, 1969. Born in 1917, he earned his M.D. degree at St. Louis in 1942. He entered the Army of the United States on completion of his internship. After three years of active military service during World War II, he was demobilized and entered into a residency in obstetrics and gynecology. Dr. Glynn then engaged in the private practice of that specialty and was on the staffs of the Newark Beth Israel Hospital, the Kessler Institute, and the St. Barnabas Medical Center. He was a diplomate of the American Board of Obstetrics and Gynecology.

Dr. Samuel M. Goldstein

On August 26, 1969, Samuel M. Goldstein, M.D., one of Essex County's senior members, died at the age of 77. Dr. Goldstein, a 1917 graduate of the medical school of New York University, was a well-known general practitioner in the Newark area until his retirement. He had been on the staffs of the Beth Israel and Doctors' Hospitals in that city, and was active in the affairs of his county medical society.

Dr. Joseph Guarraia

Born in 1898, Joseph Guarraia died at the age of 71 on July 14, 1969. He was an alumnus of the medical school at the University of Siena in Italy, receiving his medical degree there in 1924. He was active for many years in the Paterson area, and in the affairs of our Passaic County Medical Society. Dr. Guarraia served as a physician with the Regional Office of the Veterans Administration. He retired from active practice in 1967.

Dr. Otto R. Holters

Monmouth County practitioners and patients remember Otto Holters with respect and affection. He was chief of surgery at several hospitals in the Monmouth County area. Born in 1896, he died on August 24, 1969. He received his M.D. at Bellevue in 1919 and did graduate work in surgery in the Monmouth Memorial Hospital. He practiced in Asbury Park for many years and was a diplomate of the American Board of Surgery. He was a laureate of the Golden Merit Award only last May. Dr. Holters was on the faculty of the medical school of the University of Pennsylvania.

Dr. Louise Lowe

Louise Lowe, M.D. was one of the country's relatively few women chest surgeons. Born in 1905, she died on August 11, 1969 at the untimely age of 64. A Bellevue alumni (M.D. class of 1911), she became a Fellow of the American College of Chest Physicians and an associate surgeon at the Hackensack Hospital. She was one of the chiefs of chest surgery at Bergen Pines Hospital in Paramus.

Dr. Eugene A. Meyer

One of Camden County's earliest otolaryngologists, Eugene A. Meyer, M.D., died on August 7, 1969 at Medford Lakes. Born in 1903, he received his M.D. at Hahnemann with the class of 1927. For more than three decades he practiced in the Camden area, an ear, nose and throat surgeon who was well known throughout south Jersey. Dr. Meyer was a lieutenant colonel in the medical corps of the Army of the United States during World War II. He was a diplomate of the American Board of Otolaryngology, and was chief of that service at the West Jersey Hospital in Camden.

Dr. Karl Rothschild

One of Middlesex County's earliest neuropsychiatrists, Karl Rothschild, M.D., died on August 29 at the age of 72. Born in Germany, he received his medical training at both Frankfurt and Heidelberg there, earning his M.D. at the latter institution in 1921. A few years later he came to the USA and settled in New Brunswick. He did graduate work in neurology and psychiatry and eventually became chief of that specialty at both hospitals in New Brunswick. He was also active in the field of geriatrics. From 1924 to 1956 he was in New Brunswick and then switched his base to Plainfield, where he continued in private practice until his death.

Dr. Erwin Reissman

One of New Jersey's true pioneers in roentgenology, Erwin Reissman, died on August 3, 1969 at the age of 92. A 1904 graduate of the old Baltimore College of Medicine, he entered the specialty early and grew up with it, becoming director of roentgenology at several hospitals in the Newark area. Indeed, for almost 10 years he headed up the x-ray department at Clara Maass Hospital. He also served a term as president of the Academy of Medicine of New Jersey.

Dr. Roy R. Schubert

One of Passaic County's prominent orthopedic surgeons, Roy R. Schubert, M.D., died on August 28, 1969. Born in 1907, he received his medical degree from the George Washington University in 1931. Dr. Schubert was a Fellow of the American College of Surgeons, a member of the distinguished New Jersey Society of Surgeons, and of the Academy of Medicine of New Jersey. He had been on the attending staffs of the Paterson General and Hasbrouck Heights Hospitals. During World War II he served as a medical officer in the U.S. Navy, attaining the rank of Lieutenant Commander.

BOOK REVIEWS

Morris Fishbein, M.D.: An Autobiography. New York, 1969, Doubleday. Pp: 505. Illustrated. ($10)

The celebrated *affaire Fishbein* which, years ago, caused such a stir in medical circles has already receded into history, and must mean little to the present generation of younger physicians. Yet time was when the mere mention of the name of the controversial editor was enough to throw some of our more volatile colleagues into a state of mild frenzy. Fishbein was accused of being a Svengali, endowed with such powers of fascination that those who (like Balaam) came to curse remained to bless him. The tight-rope walk which Fishbein continued to perform under almost forty A.M.A. administrations remains an unparalleled feat.

Readers of this autobiography will recognize that Morris Fishbein was (and happily still is) a man endowed with intelligence, energy, imagination, and unusual powers of persuasion. He himself admits frankly that, with a few lines of his pen, he was able to "sway the point of view of almost the entire medical profession." Since his reluctant retirement some twenty years ago, he has gone on to great successes in the editorial and publishing fields. For the medical historian, however, he will always be remembered as a protagonist in the most serious internecine conflict ever to shake American medicine. I was anxious to have Fishbein clarify the particulars of this episode, but unfortunately his account proves disappointing. Instead of the detailed, fully-documented, and unbiased review one might have expected the reader is treated to a one-sided defense which fails to define the issues or dissolve the doubts as to whether the antagonism was directed against those who opposed government medicine or against Fishbein personally. Rightly or wrongly he became the target of the so-called liberals who eventually brought about his downfall.

As for the book itself I must confess, reluctantly, that reading this poorly organized, redundant, and indigestible mass proved to be quite a chore. The anecdota Fishbeiniana invariably convey an overtone of self-satisfaction or self-admiration, while the exercise in name-dropping must assuredly be the most extensive ever carried out between two covers. At a rough guess there are no less than seventeen hundred persons listed in the Index of Names. The tedium engendered by the seemingly endless recital of meetings, conferences, lectures, itineraries, and celebrities is relieved at periodic intervals by welcome flashes of the famous Fishbein wit. Yet one misses here the Pepysian humor and grace which for so many years sparkled in the *Diary* of the JAMA columns.

The discriminating reader who can skip lightly over the pages of Fishbein genealogy (there are more begats than in the Old Testament) and the fulsome letters written by relatives (resembling nothing so much in tone and theme as the typical confirmation speech) will not fail to uncover some nuggets of real interest and value. Fishbein is at his best when he can get far away from those pesty doctors and concentrate on the amenities of life. An unabashed hedonist, he admits to a love of wine, food, golf, bridge, yachts, and above all good books and conversation.

Some of the best pages of the book relate to the Chicago literary scene of the twenties and thirties and to the interesting characters who met at the local version of the Algonquin round table. Familiar sketches of such men as Ben Hecht, Horace Liveright, and Henry L. Mencken make these rugged individualists come to life.

The choppy style of the inveterate editorial writer with its truncated paragraphs and staccato sentences may reflect the boundless energy of the author, but is not at all conducive to prolonged or relaxed reading. And for a book delayed in publication for a period of two years (apparently so that it would appear in time for the eightieth birthday) there are a surprising number of minor errors in spelling and English. And at one point we learn of a "library being rebuilt . . with a shortage of books." Repetitions abound, and more careful proof-reading would have spared us the harrowing thought that poor Fishbein had to undergo two separate operations for piles.

There are other lapses of greater moment. The name of A. J. Cronin does not appear in the index, although he is mentioned twice in the text. He is treated shabbily by Fishbein because of his controversial medical novel, *The Citadel*. In even more dubious taste is the episode relating to a Herbert Lehman. Although this man is not identified as the celebrated governor and senator of New York, but rather as "the head of the May Company Stores," there seems to be no good reason for putting this unpleasant tale into print.

Fishbein has become a legendary figure in his own lifetime. Certainly no one individual did more to implement the Flexner recommendations and raise the standards of American medicine to their present heights. Perhaps only a man determined and insensitive could remain immune to the barbs of lesser men and continue doggedly on his light against quackery and malpractice. In any history of our medicine his position is assured. Yet the picture of the man which future readers may derive from this book may not be entirely flattering. There is much too much "I." Among the many humanistic interests on which Fishbein prides himself is one in the history of medicine. Unfortunately most of his occasional asides into this field are unoriginal, but in one paragraph he overreached himself. Instead of calling good old Paracelsus "Bombastus" he used the hitherto unknown form "Bombasticus," thus inventing an adjective which may well be used to describe a considerable portion of this book.

MORRIS H. SAFFRON, M.D.

Modern Treatment (Vol. 6; #13): **Treatment of Restrictive Pulmonary Insufficiency,** Edwin R. Levine M.D., Editor; **Treatment of Liver Disease,** Fenton Schaffner M.D., Editor. New York, 1969, Hoeber Medical Division, Harper and Row. ($16.00 by subscription)

This double symposium, one on pulmonary disease, and one on liver disease brings together a wealth of knowledge in simple and basic discussion for the general physician as well as many details for the specialist.

The physiologic discussions are concise and easily understood. In the pulmonary section particularly, the tables and outlines are good, with clear classifications and heavy type being used for emphasis. Some duplications of subject matter occur, particularly on positive

pressure therapy machines, but this discussion in detail by several authors gives different viewpoints which are valuable. The review of the etiology of restrictive pulmonary disease is excellent. The chapters on tracheotomy, positive pressure breathing, and assisted and controlled ventilation actually pertain more to obstructive than restrictive disease. Regrettably, no discussion of respiratory physiotherapy or the Drinker whole-body respirator is made.

The section on liver disease begins with the statement that no discussion of chronic hepatitis will be included because other excellent reviews have discussed this subject. However, a symposium of this sort ought to include some material particularly in view of the controversial nature of steroid therapy and the experimental use of immunosuppressive therapy. Popper's discussion of cholestosis from various drugs should have offered a complete list of drugs causing liver injuries. Leevy's discussion of pulp pressure measurements should have included a discussion of means of obtaining this measurement. Some of the chapters in the liver section lacked summaries. The range of subjects covered is broad, and of interest to the generalist as well as the specialist.

ELLIS P. SINGER, M.D.

William Henry Welch and the Heroic Age of American Medicine. Simon Flexner and James Thomas Flexner. New York, 1966. Dover Publications, Inc. Pp. 539. Illustrated. ($3.00)

This Dover paperback is an unabridged, corrected republication of the book first issued by The Viking Press in 1941. It is a welcome, inexpensive volume which will prove widely useful.

William Henry Welch (1850-1934), grandson and son of Connecticut physicians, was a graduate of Yale College and the College of Physicians and Surgeons in New York. Following graduate studies in Germany, he founded America's first pathological laboratory, in 1878, at the Bellevue Hospital Medical College (now New York University School of Medicine).

In 1885 Dr. Welch became professor of pathology at The Johns Hopkins University, as well as the guiding spirit and first dean of its newly-formed medical school. From that time until the end of his long life, he was a leader in the development of the Schools of Medicine and Public Health and the Institute for the History of Medicine at Johns Hopkins. His research in microbiology and pathology and his medical statesmanship benefited all mankind.

The Flexners' readable, well-annotated chronicle recalls Welch, eminent pathologist, teacher and administrator, and his circle. "Popsy" Welch and the other three giants portrayed vividly on canvas by John Singer Sargent (William Osler, William S. Halsted, and Howard A. Kelly) live again in these pages. On Welch's eightieth birthday (1930), an international celebration was held in his honor, including a private audience with President Herbert C. Hoover. Dr. Welch's reputation was by then world-wide and it so continues to this day.

FRED B. ROGERS, M.D.

Collateral Circulation in Clinical Surgery. D. D. Strandness, Jr., M. D. Philadelphia, 1969, Saunders. Pp. 633. Illustrations 242. ($18.50)

This multi-authored book covers a broad range. It is well edited by Dr. Strandness. Considerable progress has been made in our knowledge of collateral circulation since Antyllus noted that the ligation of an artery did not necessarily result in loss of the part served by the vessel. The contents of the book show such great gain in our knowledge of collateral circulation.

The book begins with a very lucid section on some aspects of the physiology of normal circulation and then treats in detail the general characteristics of collateral circulation. Also offered is an extensive discussion of the control mechanisms in terms of specific "vascular beds." These are lungs and heart, thoracic aorta, upper and lower extremities, stomach, pancreas, liver, spleen and kidney, small and large intestine, the brain in terms of extra cranial arterial circulation, and the arterial collateral circulation of the nervous system. The editors provide us with a worthwhile and detailed analysis of the problem of arteriovenous fistula.

The combination of excellent photographic reproductions (both clinical and x-ray) and the fine black and white schemata is helpful in understanding the text throughout.

Typographically attractive, the book is bound in a bright arterial red, certainly appropriate to its subject.

Reference libraries will find the book very useful. Surgeons doing vascular work will recognize a good companion worthy of personal ownership. The book carries my hearty recommendation at all levels.

ROBERT K. SPIRO, M.D.

Todd-Sanford Clinical Diagnosis by Laboratory Methods. Israel Davidsohn, M.D. and John B. Henry, M.D. (14th Edition). Philadelphia, 1969, Saunders. Pp. 1308. Illustrations 698. ($24)

The latest edition of this excellent text and laboratory manual represents the efforts of 29 contributors. The book is entirely rewritten, expanding the traditional areas and adding new ones. Subjects include: urine and renal function; hematology; coagulation and hemastasis; radioactive isotopes; clinical chemistry; hepatic function; serum enzymes; pancreatic disorders; gastrointestinal contents; microbiology; serology; body fluids and secretions; pregnancy tests; cytogenics; and even planning a medical diagnostic laboratory. New chapters cover spectrophotometric instrumentation; endocrine measurements; and, examination of amniotic fluid.

This is both a reference text and working manual, useful to technicians and physicians alike, at all levels of training and experience. It discusses clinical pathology as the procedures are done by hand, with only a brief review of the theory and (some of the practical applications) of automation.

As a working manual for the technician and pathologist, and as a text for students, it has a valuable place along with similar texts. The index is adequate, and the illustrations are excellent. Each section explains the usefulness and theory of a test, how to set it up, how to perform the test, and possible sources of error. References are as recent as 1967.

The field of clinical pathology is rapidly moving into the era of automation. Hematology, clinical chemistry, and certain other tests are becoming automated. With this advance, an entire body of knowledge is emerging. Future editions of this volume will probably reflect this change more substantially than the present edition.

ALLAN LAZAR, M.D.



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We wish to thank Drs. Marcia K. Bilbao, Louis Frische, Josef Rösch and Charles T. Dotter for this exc tionally graphic example of hypotonic duodenograp

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Contraindications: Glaucoma, severe cardiac disease.

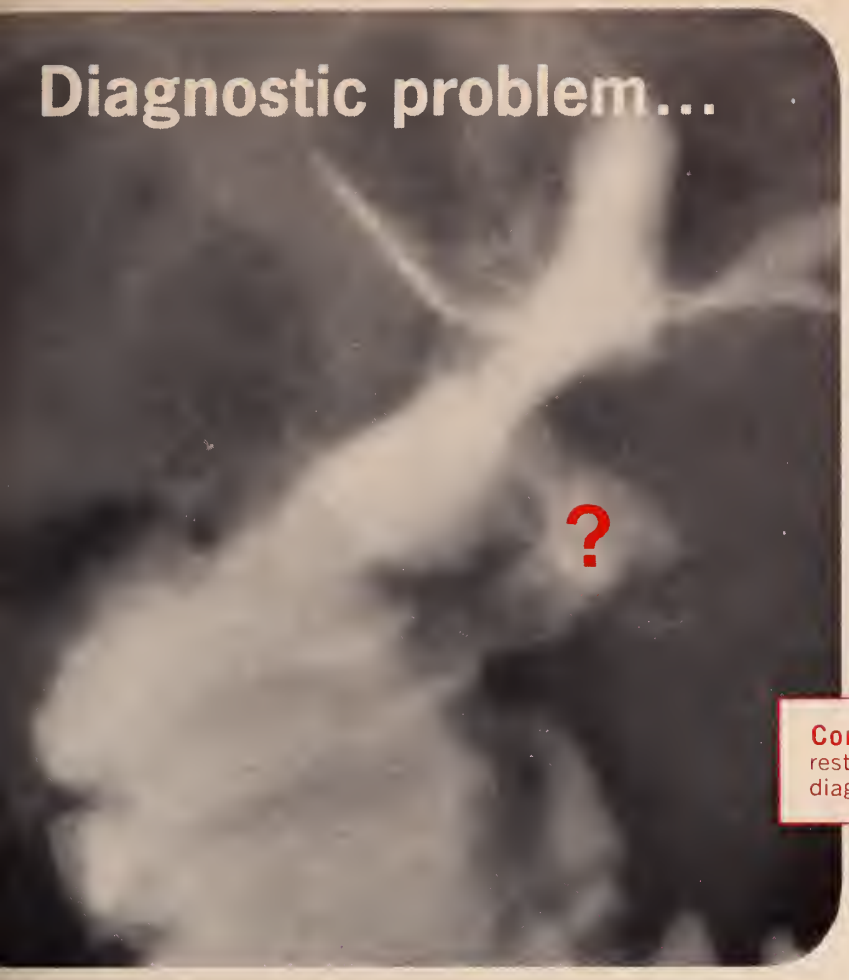
Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

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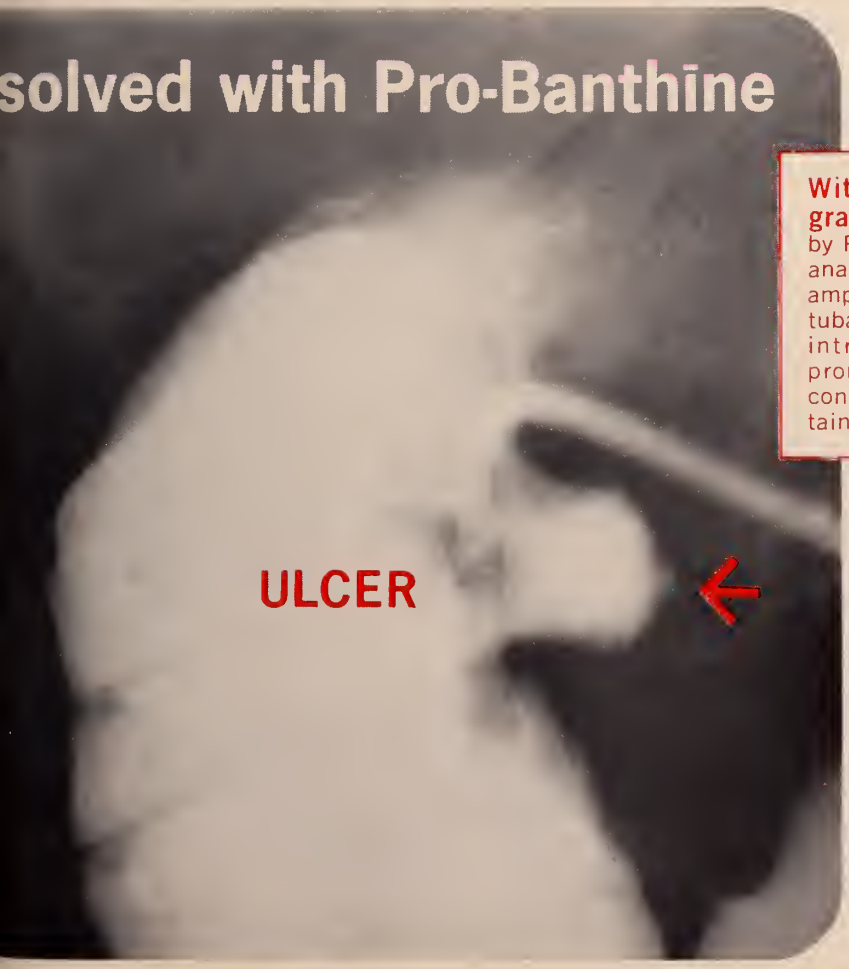
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As is characteristic of sympathomimetic agents, it may occasionally couse CNS effects such os insamnia, nervausness, dizziness, anxiety, and jitteriness. In cantrast, CNS depressian has been reported. In a few epileptics on increase in canvulsive episodes has been reported.

Sympothomimetic cordiavascular effects reparted include ones such as tachycordio, precordiol pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy yaung male after ingestion of diethylpropian hydrochloride; this was an isalated experience, which has not been reported by others.

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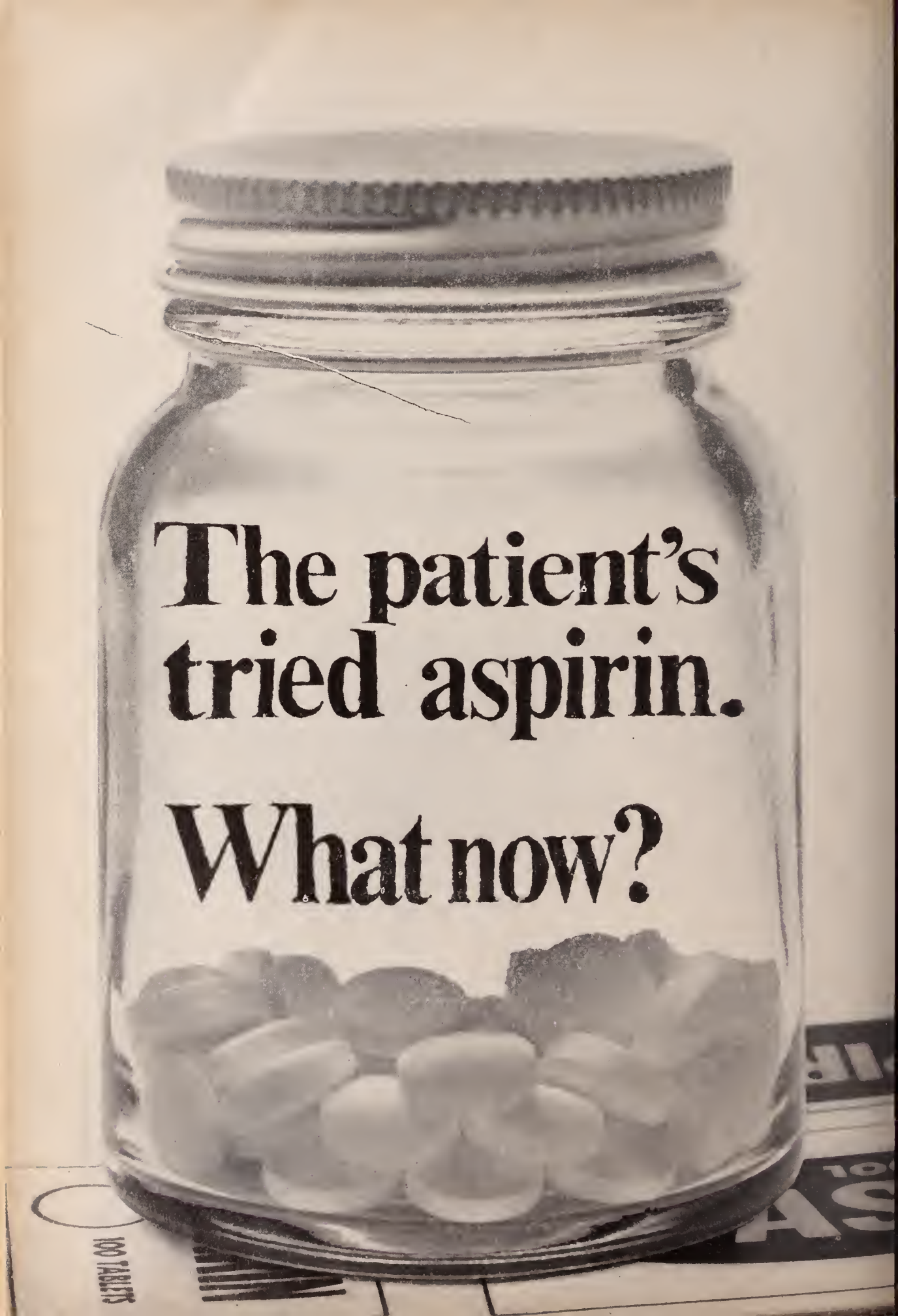
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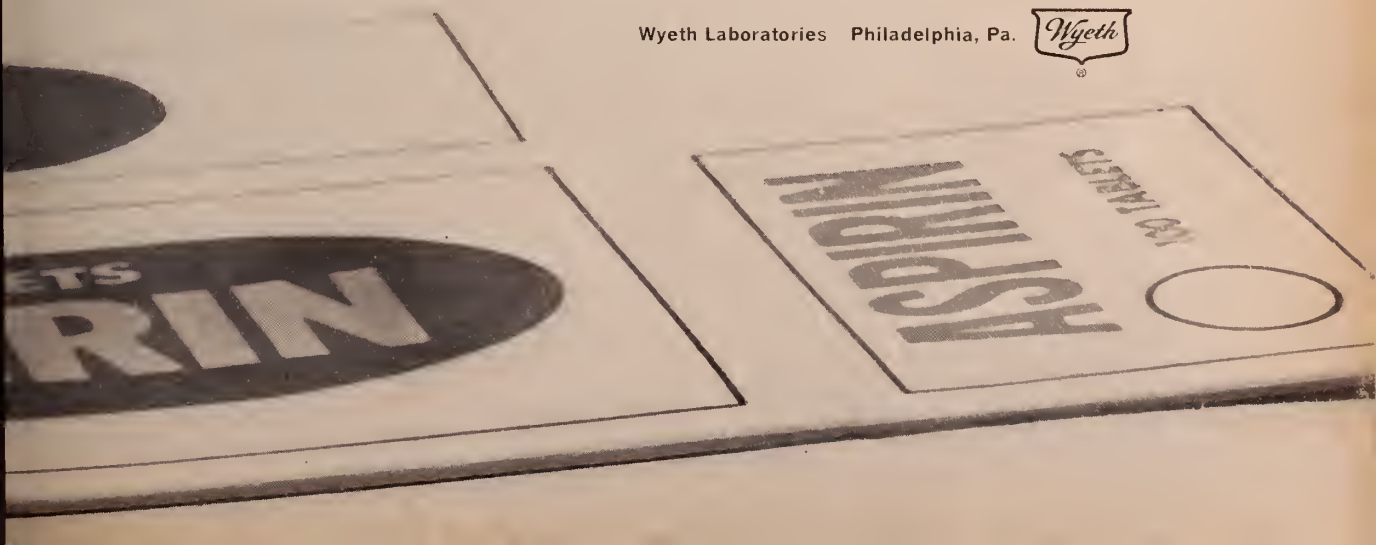
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



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INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

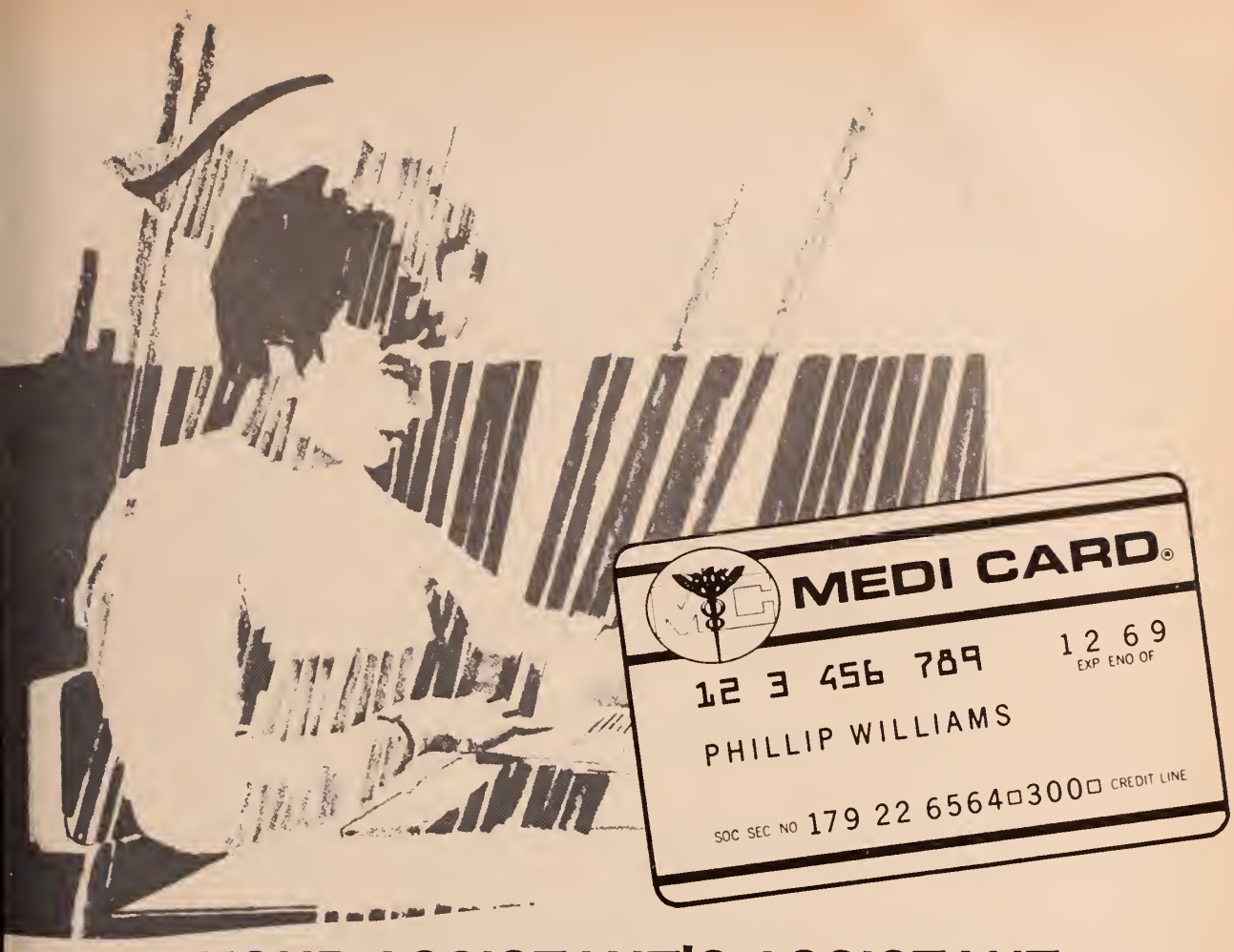
SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and oth depressants. As with all CNS-acting dru tion patients against hazardous occupat quiring complete mental alertness (*e.g.*, o machinery, driving). Though physical a chological dependence have rarely been r on recommended doses, use caution ministering Librium (chlordiazepoxide chloride) to known addiction-prone ind or those who might increase dosage; wit symptoms (including convulsions), fo discontinuation of the drug and similar t seen with barbiturates, have been report of any drug in pregnancy, lactation, or in of childbearing age requires that its p benefits be weighed against its possible h As with all anticholinergic drugs, an in effect on lactation may occur.

PRECAUTIONS: In elderly and deb limit dosage to smallest effective amount clude development of ataxia, overseda confusion (not more than two capsules initially; increase gradually as needed an

or here.



Though generally not recommended, if nation therapy with other psychotropics indicated, carefully consider individual acologic effects, particularly in use of po- ing drugs such as MAO inhibitors and thiazines. Observe usual precautions in ce of impaired renal or hepatic function. xical reactions (*e.g.*, excitement, stimula- rd acute rage) have been reported in psy- c patients. Employ usual precautions in ent of anxiety states with evidence of im- g depression; suicidal tendencies may be t and protective measures necessary. Vari- ffects on blood coagulation have been d very rarely in patients receiving the nd oral anticoagulants; causal relation- s not been established clinically.

ERSE REACTIONS: No side effects or stations not seen with either compound have been reported with Librax. When iazepoxide hydrochloride is used alone, ness, ataxia and confusion may occur, lly in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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for unearthly cough

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EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

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ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

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ANDROID	GOOD TO EXCELLENT 75%
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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
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6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesono, Evongelista: Clinicol Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Botttes of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Botttes of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each oronge tablet contains:
Methyl Testosterone ..12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
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Android-E

Each Toblet Contains:
Methyl Testosterone ..... 2.5 mg.
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Glutamic Acid ..... 50 mg.

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Write for literature and samples:

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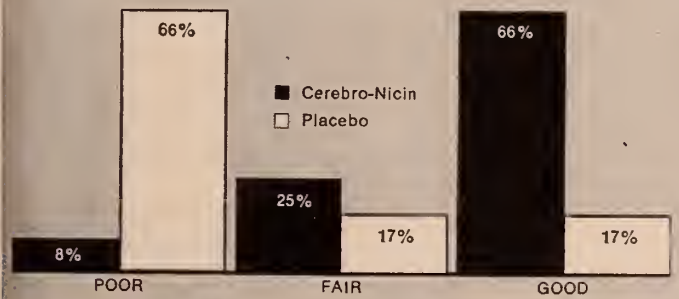
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Each Cerebro-Nicin capsule contains:

Pentylenetetrazole ..... 100 mg.
Nicotinic Acid ..... 100 mg.
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1-Glutamic Acid ..... 50 mg.
Niacinamide ..... 5 mg.
Riboflavin ..... 2 mg.
Pyridoxine ..... 3 mg.

DOSAGE One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.

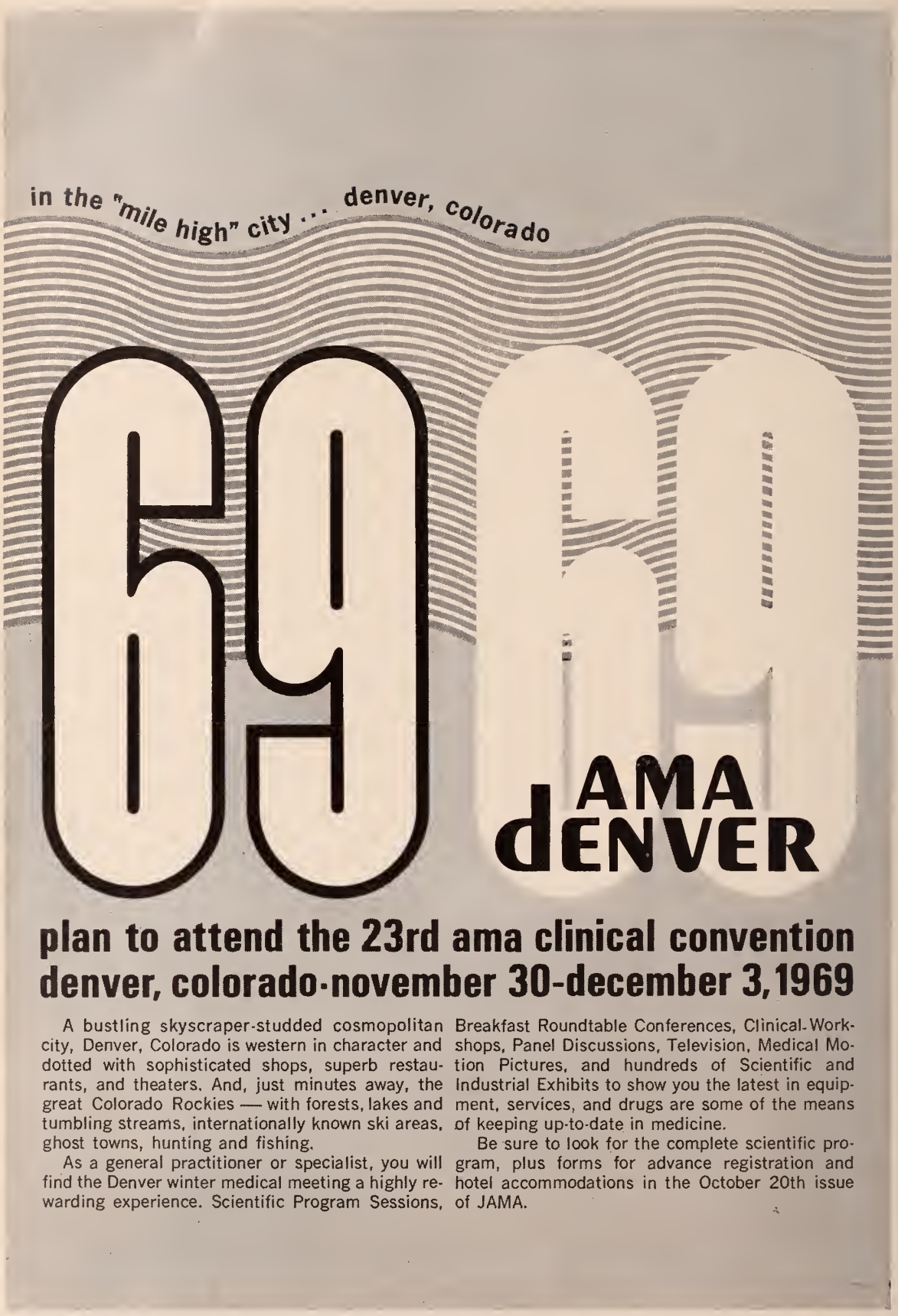
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some witl complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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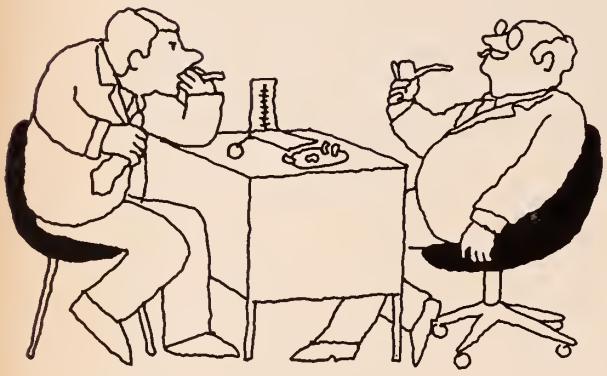
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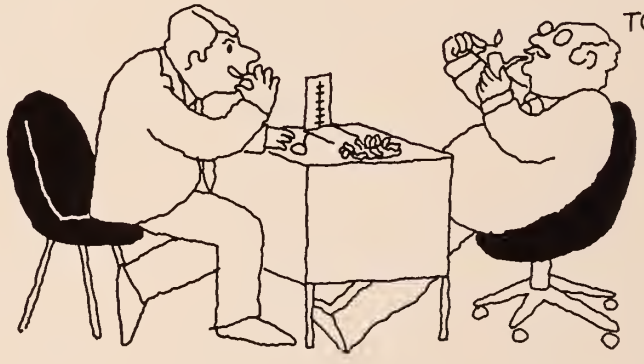
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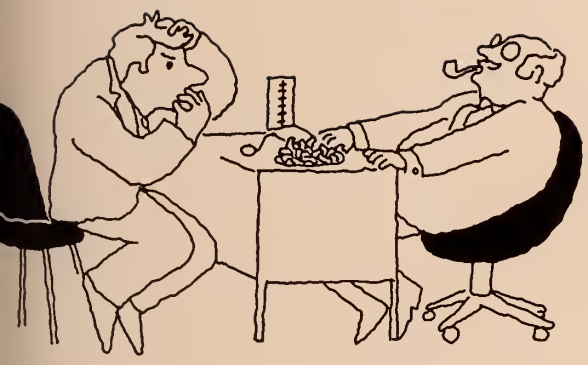


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chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

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WE'VE GOT PROBLEMS.



nd allay anxiety in hypertension

osteroids, ACTH, or digitalis. Severe salt restriction is not recom-ed. Use cautiously in patients with ulcerative colitis or gallstones ry colic may be precipitated). Bronchial asthma may occur in eptible patients. *Adverse Reactions:* The drug is generally well ted. The most frequent side effects are nausea, gastric irritation, ing, diarrhea, constipation, muscle cramps, headache, dizziness cute gout. Other potential side effects include angina pectoris, ly, depression, bradycardia and ectopic cardiac rhythms (espe- when used with digitalis), drowsiness, dull sensorium, hypergly- and glycosuria, hyperuricemia, lassitude, restlessness, transient ia, impotence or dysuria, orthostatic hypotension which may be tiated when chlorthalidone is combined with alcohol, barbiturates rcotics, leukopenia, aplastic anemia, skin rashes, thrombocyto- agranulocytosis, nasal stuffiness, increased gastric secretions, mare, purpura, urticaria, ecchymosis, weakness, uveitis, optic ny and glaucoma, and pruritus. Eruptions and/or flushing of the a reversible paralysis agitans-like syndrome, blurred vision, con-val injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

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chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

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Pages 31A, 32A

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ADDITIONAL PERSONNEL REQUIREMENTS SEE PAGE 30A AND 32A

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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the JOURNAL
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NOVEMBER 1969
VOL. 66, NO. 11

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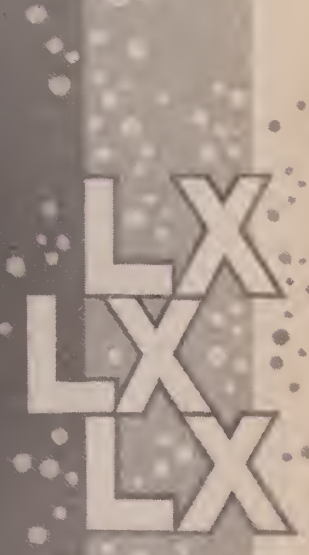
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eferences:
) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., :19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965.) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, . J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., nes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: ral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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The Journal is published monthly (since 1904), under the auspices of the Board of Trustees and the direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. Printed in East Stroudsburg, Pennsylvania, by the Hughes Printing Company. Whole number of issues 783.

Each member of the Society is entitled to receive a copy of *The Journal* every month. The price of a yearly subscription ($2.50) is included in the dues of Society members.

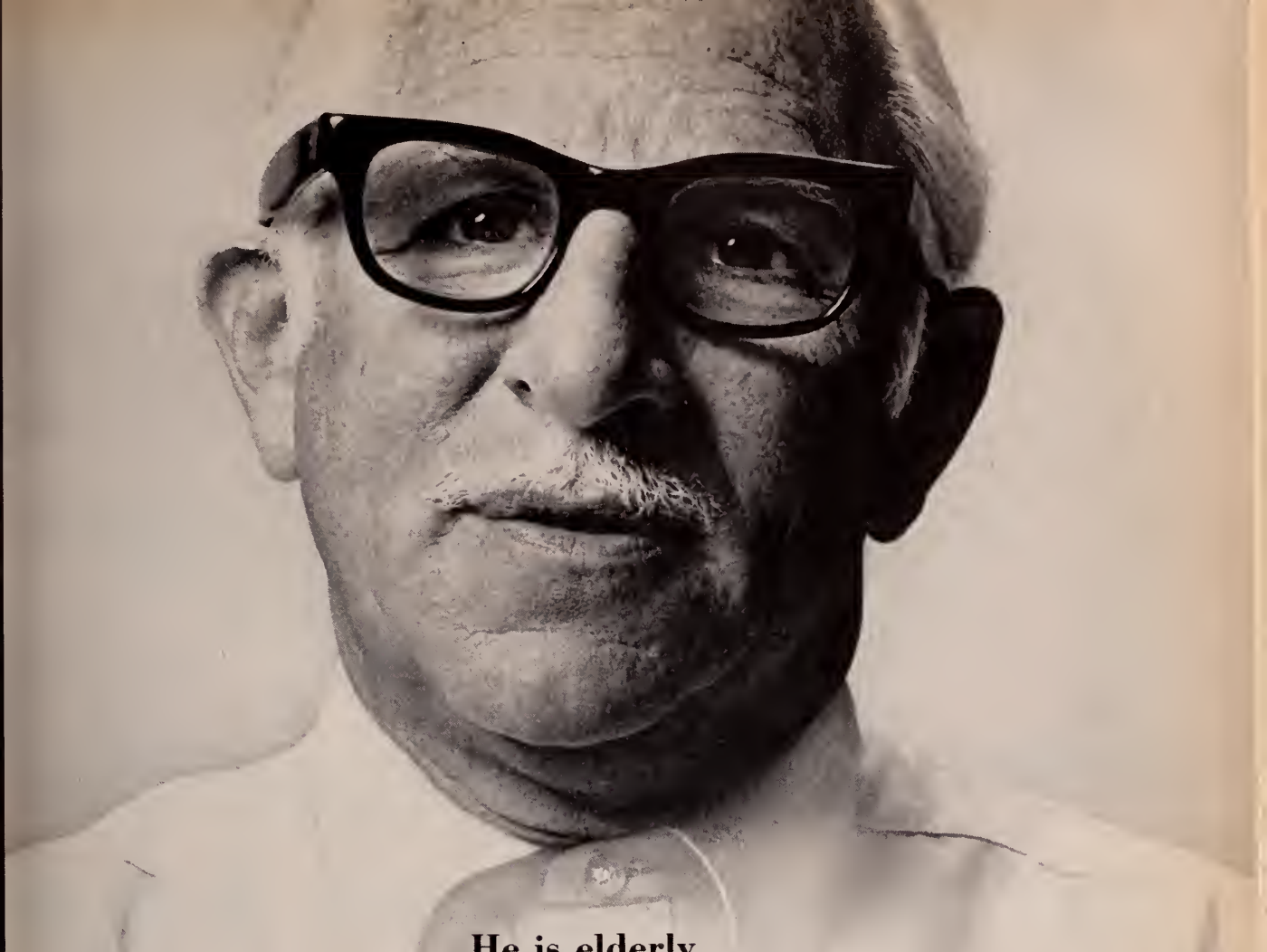
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Address all communications to *The Journal*, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605. Phone: 609-394-3154.

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raindication: History of hypersensitivity to demethylchlortetracy- or nystatin.

ning: In renal impairment, usual doses may lead to excessive accumon and liver toxicity. Under such conditions, lower than usual doses ndicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sunhas been observed. Small amounts of drug and short exposure may uce an exaggerated sunburn reaction which may range from erya to severe skin manifestations. In a smaller proportion, photogic reactions have been reported. Patients should avoid direct sure to sunlight and discontinue drug at the first evidence of skin mfort. Necessary subsequent courses of treatment with tetracys should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

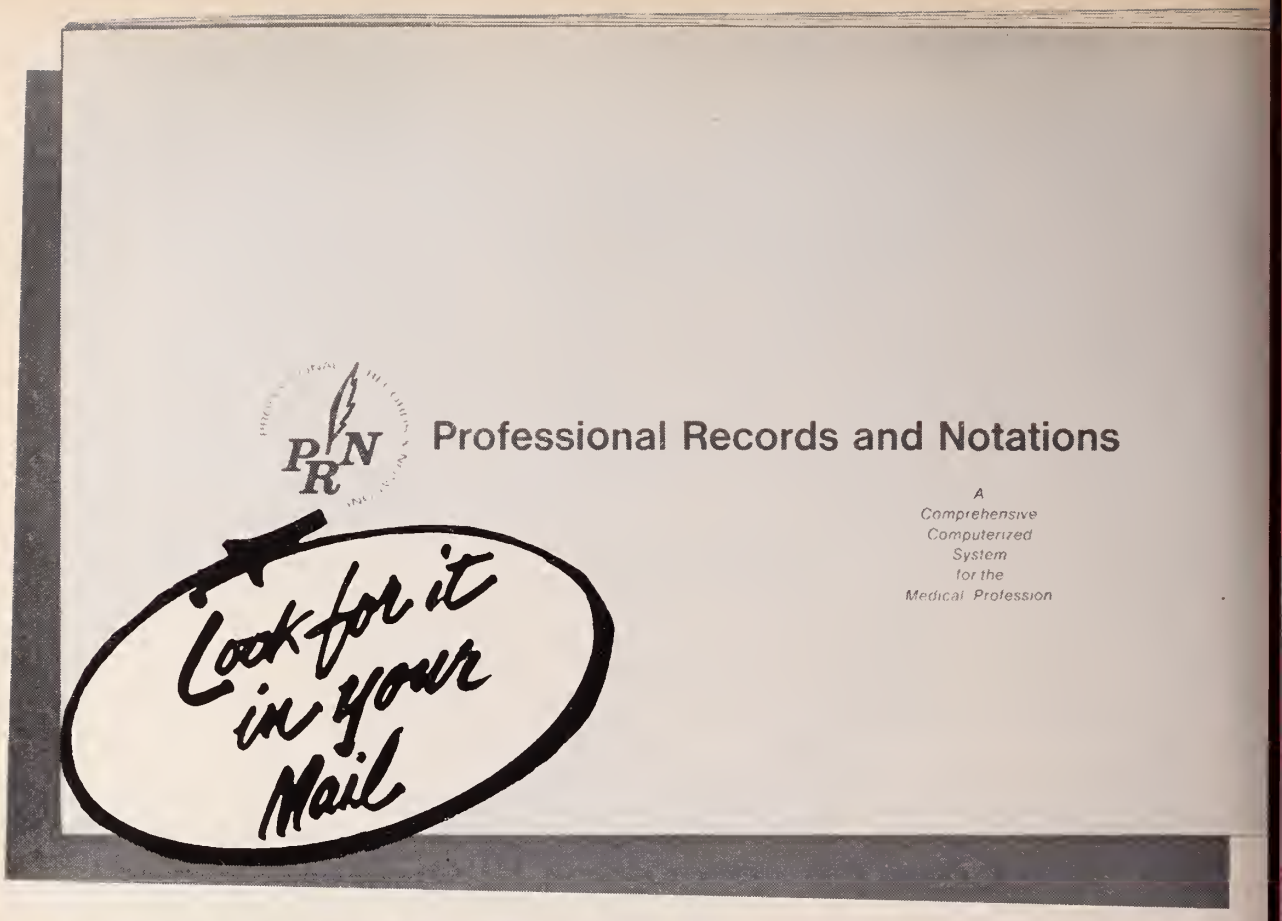
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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2. The Blues returned about 90% of their premium income in benefits paid to providers on behalf of subscribers, compared to 83% by commercials.
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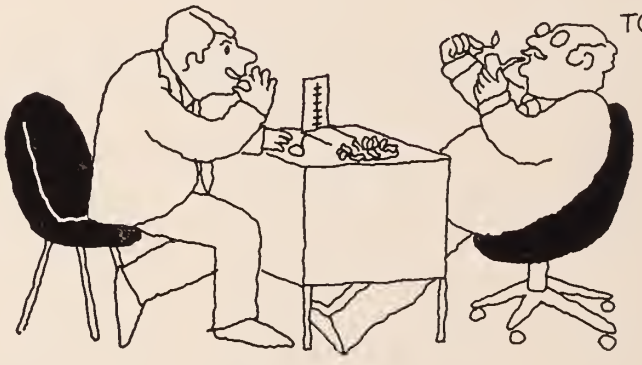
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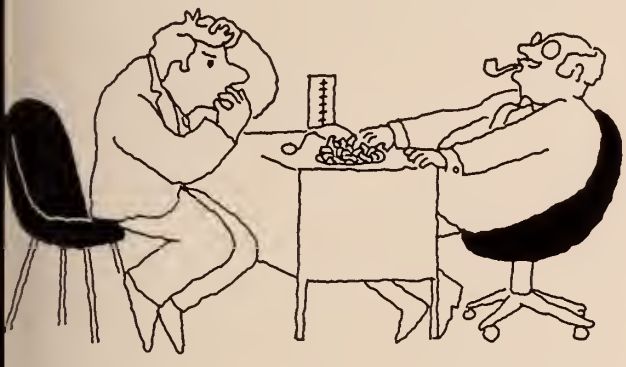




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and allay anxiety in hypertension

orticosteroids, ACTH, or digitalis. Severe salt restriction is not recom-ended. Use cautiously in patients with ulcerative colitis or gallstones iliary colic may be precipitated). Bronchial asthma may occur in usceptible patients. *Adverse Reactions:* The drug is generally well -lerated. The most frequent side effects are nausea, gastric irritation, omiting, diarrhea, constipation, muscle cramps, headache, dizziness nd acute gout. Other potential side effects include angina pectoris, nxiety, depression, bradycardia and ectopic cardiac rhythms (espe-ially when used with digitalis), drowsiness, dull sensorium, hypergly-emia and glycosuria, hyperuricemia, lassitude, restlessness, transient yopia, impotence or dysuria, orthostatic hypotension which may be otentiated when chlorthalidone is combined with alcohol, barbiturates r narcotics, leukopenia, aplastic anemia, skin rashes, thrombocyto-enia, agranulocytosis, nasal stuffiness, increased gastric secretions, ightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic trophy and glaucoma, and pruritus. Eruptions and/or flushing of the kin, a reversible paralysis agitans-like syndrome, blurred vision, con-unctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

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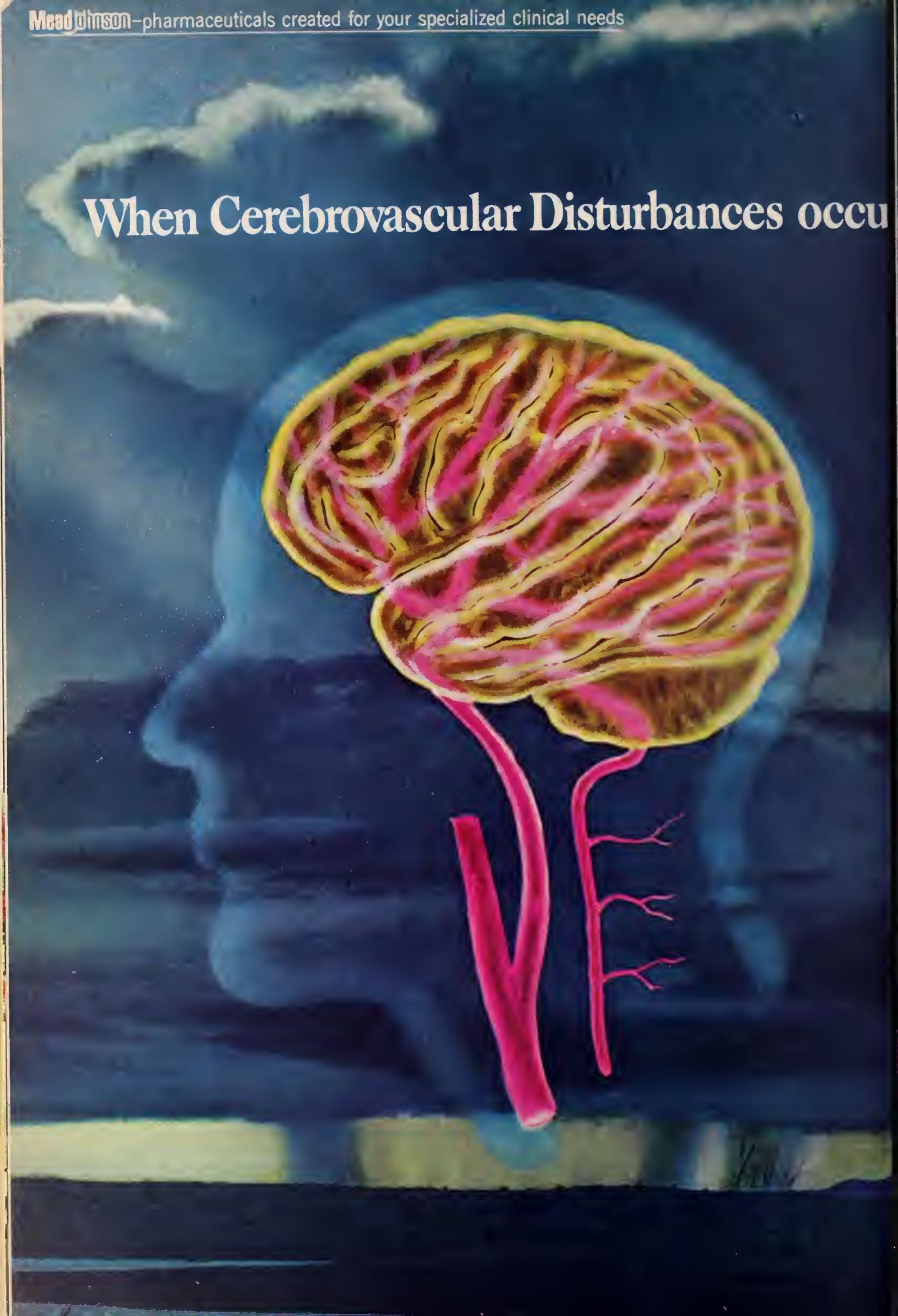
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ugh not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of uprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]

cations: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), aud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **position:** VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial ding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete ils available in product brochure from Mead Johnson Laboratories **References:** (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, ., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, G E , and Johnson, P C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, and LePere, D M · Angiology *11*:190-192 (June) 1960 (4) Dhrymiotis, A D , and Whittier, J R.: Current Therapeutic Research *4*:124-128 (April) (5) Whittier, J R.: Angiology *15*:82-87 (Feb) 1964

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TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

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Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

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TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasia (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, u to exfoliative dermatitis); other allergic reactions (asthma laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes catatonic-like states; autonomic reactions such as drynes of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, an phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, includin peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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The characteristic blue/green urine tells the patient that something is happening. The patient generally tells you that symptomatic relief follows the first dose.

REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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Each Blue-Coated Tablet contains Active:

Atropine Sulfate	0.03 mg.	Methylene Blue . .	5.4 mg.
Hyoscyamine . .	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine . .	40.8 mg.	Benzoic Acid . . .	4.5 mg.

PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease.

SIDE EFFECTS: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

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Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

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Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

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oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

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By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation... *for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris... the fibrin in blood clots, serum, and purulent exudates... and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

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Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

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EDITORIALS

November Is Life Month

This is the ninth annual life month for The Medical Society of New Jersey Life Insurance Plan. During this month, members under age 65 are invited to apply for life insurance under this State Society approved plan.

More than 1,700 of our members participate in the program and actual claim payments to beneficiaries exceed $1,650,000. The low cost, high quality, and generous limits of the Society's life insurance plan make it possible for members to plan their life insurance programs more adequately.

Increased life insurance protection is generally required when your income has increased, your standard of living improved, your responsibilities grown, or your cost of living has gone up. The low net premium of the Society's program keeps the cost of this valuable coverage so low that members can afford to build an adequate insurance program.

Up to ten $10,000 units of term life insurance are available, making the maximum life insurance protection $100,000. There is no extra premium charge for the double indemnity benefit for accidental death, or for the waiver of premium benefit.

The policy has a guaranteed right of conversion without medical examination, regardless of health history or physical condition. The importance of this right is evidenced by the fact that more than 600 members have converted their term policies to various forms of permanent insurance, with cash values and steadily increasing dividends.

Complete information is being sent members by the administrator, E. & W. Blanksteen Agency. Possibly you have already received your letter in the mail. For personal help, call the agency collect at (201) DE 3-4340.

Critics From Within

Every once in a while a physician makes a public statement about defects in the American medical care system. And such a statement, being seen as something the lawyers call "an admission against interest," immediately acquires wings. A reader* of the *Hospital Tribune* (issue of August 11, 1969) put it well in a letter to the editor:

"The doctor who occupies a position of honor and speaks for public consumption, such as Dr. Robert Ebert, dean of Harvard Medical School, bears a heavy burden. If he even hints that American medicine may not be all bad or perhaps the intentions, at least, are good, there is no problem because his words will die a-borning. If, however, his tongue is vitriolic and his words acidic they will be carried swiftly across this land and will overfly the oceans to flood into foreign countries with all the speed of an ugly rumor. This message of criticism will be carried and spread with speed and skill, frequently by those who are not friends either of America or of American medicine. The words will be given wide publicity because of the high position held by the man who speaks. It is not the man but the position that is actually speaking. Because a man is an able administrator and runs an efficient medical school does not necessarily mean that he is the ultimate authority on the ills of medicine today."

Certainly every physician has a right to criticize his professional colleagues, to take pot shots at the AMA and his state society, and to tell the world what he thinks is wrong about our system of distributing medical care. Still, there are some disadvantages to fouling one's own door steps and the more effective way to correct evils would seem to be by working within the established organization than to join an anvil chorus being pounded out on the outside. At the very least, the physician who feels impelled to make adverse public statements about his medical brethren should, in all fairness, point out that it isn't all bad

* Thomas J. McKenna, M.D. of Johnstown, Pennsylvania.

and that there *are* more remunerative ways of making a living than trying to practice medicine — if that is all one seeks. Boswell quotes Samuel Johnson as having once said that, "A fly may sting a stately horse and make him wince. But the fly is still an insect and the horse is stately still." Our outside critics, asked what changes they would make, can reasonably answer that this is not their field. But when a physician himself is ready to tell the public what is wrong about his profession, he should also be able to suggest how it may be righted.

One Big Health Agency?

The dimes march is in January; you are asked to have a heart and give to the Heart Fund in February. Crippled Children make an Easter appeal and the American Cancer Society calls to you in April. Mental Hygiene week is in May and the Multiple Sclerosis key signs appear in June. And so it goes through the year — Muscular Dystrophy, Nephrosis, Arthritis, Cerebral Palsy and on to Christmas when the colorful seals of the Tuberculosis Association appear in street booths.

To most medical practitioners, there seems — at first — something wasteful about this confusing grab bag of appeals. It occurs to many that it would be more efficient to unite them into a single voluntary health organization and thus reduce the number of executive secretaries, directors, clerks, and other personnel whose salaries are a first lien on the funds collected. And in a strictly logical sense, this indeed would seem sound.

But the whole operation is emotional rather than logical — and must be seen in that frame. It may make good sense but it doesn't reflect much knowledge of human nature to ask the officials, employees, advisers, and boards to surrender their autonomy for the common good. Then too, people want to give to a cause that means something to them emotionally. The parent of a cardiac child is more likely to give generously to the Heart Fund than to an omnibus organization which finances cardiac research as a minor activity. The widower of a woman who died of carcinoma is more likely to donate money to a Cancer Society than to a general health organization. And in a general health organization, there will be constant disagreement over the division of funds. The "one big health agency" idea may be logically sound and may sound logical. But there is something to be said for the apparently inefficient system of a separate organization for each major disease. It fits into the peculiarities of human nature.

Limits Of FDA Control

On page 633 of this issue, we publish an account of the struggle between the pharmaceutical industry and the Food and Drug Administration about the agency's right to take certain drugs off the market without a hearing. Many Government regulating agencies are charged with being too friendly to the businesses they are supposed to regulate. The FDA (like the FCC, SEC, and others) has not escaped such charges. On the other hand, the pharmaceutical industry feels that the FDA is not sufficiently understanding of their problems. The forefront issue now is the distribution of antibiotic combinations, which FDA says are unnecessary but which many medical practitioners find convenient and helpful. The Pharmaceutical Association replies that in supplying the combinations they are meeting a need expressed by physicians. FDA retorts that, by their advertising, they have prompted the demand. (FDA had approved the advertisements, however!)

FDA's medical advice comes largely through the National Academy of Sciences, a prestigious, academically oriented organization which, some doctors feel, is closer to academic matters than to the every-day problems of the clinical practitioner. Both sides of the controversy are certainly interested in the same thing; better care of patients. Having solved the problem of getting men on the moon, we ought to be able to solve this earthier earth-bound problem next.

ORIGINAL ARTICLES

Here is one problem that can't be fed into a computer . . . or can it?

The Diagnosis Of Life And Death*

Christopher T. Reilly, M.D./Ridgewood

Death has been defined as the permanent cessation of physical and chemical processes upon which the phenomena of life depend. It is easy to apply this definition to biologic death of individual cells. Clinical death, however, with the cessation of apparent life function, may occur even though many of the body cells or organs remain alive. The definition which remains unchanged in the current edition of Black's Law Dictionary is, "The cessation of life: the ceasing to exist; defined by physicians as a stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, et cetera." But, with the advent of devices such as the defibrillators, pacemakers, artificial respirators, and many others it is possible to keep a person clinically alive even though irreversible coma has occurred. When brain death has been established, keeping the respirator going only delays the inevitable, clinical death.

One can become totally useless to society even though conscious or semi-conscious, such as a patient with terminal cancer. Efforts to prolong life cause unnecessary discomfort until finally the inevitable occurs. The patient is essentially dead to society, but not permitted to die in dignity.

It would seem important then to differentiate whether one is talking about biologic death, clinical death, brain death, organ death, social death, or theologic death.

Regardless of one's moral standard or frame of reference, the sanctity of life is the principle that causes us to question our attitudes toward death. The moral dilemma is due to the fact that there is no "moment of death" as we like to think of it. Death is a process. This causes difficulties in our thinking. I will limit my discussion to four practical medical situations: (1) The Determination of the Time of Death and Its Significance, (2) The Socially Dead Patient with Incurable Terminal Disease, (3) Heroic Treatment of Cardiac Arrest, and (4) Donor Selection for Organ Transplantation.

1. *The Determination of the Time of Death and Its Significance*

When you and I as physicians sign a death certificate we are asked to record the time of death. What we actually record, however, is the time at which the individual is *pronounced* dead. One looks for vital signs. After some time has elapsed and no vital signs are noted the patient is pronounced dead and an arbitrary time is selected. Usually, the exact time selected is of little importance. Holman,[5] however, has recorded several decisions which depended upon the time of death such as the problem of determining the heirship when husband and wife die in a common disaster. Determining which one took the last gasp (or even autopsy findings that one died immediately while the other developed congestion or other conditions indicative of a slower death process) has been used as evidence to decide who should be the heir of an estate. There have been incidents where the time written on the death certificate was the only available evidence.[1]

* Read before the Special Session on Diagnosis of Life and Death, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1969.

Consider this hypothetical situation: a woman with terminal cancer has much pain. With the use of blood transfusions, she might gain a few extra days or weeks of life. Most would agree that active intervention of this sort would not be indicated but few would criticize the use of such treatment particularly if it would keep a mother alive long enough to permit a son to return home from Vietnam before death occurred. Now, let us complicate this hypothetical situation by adding a husband who also has a terminal condition. You happen to know certain facts about their wills. If his time of death precedes his wife, who is your patient, your favorite charity will receive the bulk of the estate, whereas, if her death precedes his, the funds will go in another direction. Would this alter your care?

2. *The Socially Dead Patient with Incurable Terminal Disease*

Without consideration of the ethical factors, three options are apparent when treating the incurable patient (1) active treatment for maximum prolongation of life, (2) passive management in order to shorten the dying process, (3) active intervention to end life: that is, euthanasia. Many factors might be taken into consideration when treating an incurable patient. A partial list is presented here.

1. The infinitesimal chance of recovery or the likelihood that a cure might be discovered if life is prolonged.

2. The presence of continued excruciating pain in an otherwise doomed patient.

3. The effect of useless treatment on the financial situation of the family.

4. The waste of physician's time, nurse's time, hospital supplies, and hospital facilities which might be used more profitably in caring for patients with a more expectant prognosis.

5. The legal relationship of the doctor and his patient. These have been reviewed by Fletcher[4] who emphasizes the physician's legal responsibility if the patient has requested that his life be maintained even if he has a flat electroencephalogram.

6. What is meaningful life?

Much has been written about euthanasia but in general most would reject such active intervention with possibly one exception, i.e. the use of narcotics, analgesics, or sedatives to make a terminal patient more comfortable even though the depression of vital functions may be sufficient to hasten the patient's demise.

There are two biblical references to euthanasia. King Saul in I Samuel 31:4, after he was wounded, asked his armor bearer to kill him lest the Philistines when they capture Saul would abuse him. When the armor bearer refused, Saul committed suicide. Abimelech in Judges 9:54 suffered a fractured skull when hit on the head by a stone thrown by a woman. He asked his armor bearer to slay him so it would never be said that a woman slew him. The armor bearer obliged.

In contrast to euthanasia, passive management by a physician, bestowed with a sensitivity to the moral issues and in consultation with the family seems reasonable, but there is always the possibility of being moved by lesser motives. Nevertheless as physicians we cannot evade the unpleasant responsibility of giving up a useless struggle. What is gained if active treatment prolongs life if it results in added days of intolerable suffering or days spent in a vegetative state?

3. *Heroic Treatment of Cardiac Arrest*

There have been instances where active immediate resuscitative technics have been very rewarding if accomplished without too much delay after the cardiac arrest has occurred. All too often the patient is "brought back to life" (as we say) only to find that permanent brain damage has resulted and that the efforts were in vain. Nevertheless, in the absence of other terminal conditions, such as cancer, every means available should be used until it is obvious that success is impossible. Resuscitation of the newborn has at times been particularly rewarding. Many infants who did not breathe spontaneously for as long as 40 minutes have grown to be healthy children. The risk of course is one with cerebral palsy.

4. *Donor Selection for Organ Transplantation*

Moore[6] observed that a number of eminent persons, who appear to be shocked and startled by heart transplants (as evidenced by their public statements) were silent, apathetic, and uninvolved as distant spectators, during the preceding seventeen years of kidney transplantation. This observation is more significant when one realizes that the heart is more resistant to the damage that results from lack of blood-flow than the kidneys and little time can be wasted once the kidney donor has been declared dead. Does the figurative use of the word "heart" in our daily language influence our emotions? The word heart appears over 900 times in the King James Version of the Bible but on only one occasion does it refer to the physical heart. Our thought processes occur in the central nervous system which is easily permanently damaged by anoxia. Due to modern mechanical and electronic inventions it is possible artificially to maintain cardiopulmonary function even though a permanently non-functioning brain is present. Simply "pulling the plug" would result in the classical signs of death. These individuals are for all practical purposes dead and at times represent excellent donors for organ transplants.

The *ad hoc* Committee of the Harvard Medical School[2] has attempted to define irreversible coma or "brain death" in order to avoid controversy. The essential points are: (1) unreceptivity and unresponsitivity, (2) no movements or breathing, (3) no reflexes, and (4) a flat electroencephalogram. Public education will be necessary if there is a movement to upgrade the diagnosis of death by electroencephalogram since it has been demonstrated[1] that most people think of death in terms of cessation of cardiac function. One could foresee a conflict of interest if the physician of the potential donor were also caring for the potential recipient of a transplantable organ. With this in mind, the recommended Uniform Anatomical Gift Act[7] as approved by the National Conference of the Commissioners on Uniform State Laws contained a provision that the physician who certified the death shall *not* participate in the procedure for removing or transplanting a part. Similar recommendations were made by the World Medical Assembly.[3]

Life

Now, let us direct our attention to the diagnosis of life, particularly as it is related to induced abortion. For the most part, regardless of our religious persuasion, our attitudes are related to the influence of Judeo-Christian ethics. Specific biblical revelation is lacking concerning the subject of abortion but principles are established which are related to the subject such as (1) the sacredness and value of human life, (2) the sanctity of marriage and family life, (3) distorted human relationships, unwanted children, genetic defects, and harmful social conditions that are the result of a world pervaded by evil, and (4) the need for individuals to act in love for God and man by being compassionate to individuals and seeking responsibility to mitigate the effects of evil.

Since specific Biblical references to abortion are lacking, different opinions result because different weight may be given to different principles in any given situation. These are discussed in great detail in a recent book published by the Christian Medical Society[8] entitled *Birth Control and the Christian.* There is one reference to an induced abortion in the Old Testament in Exodus 21:22-24. In modern English it says if a man injures a pregnant woman so that she has a miscarriage, the woman's husband will go to the judge who will assess the fine. The miscarriage is looked upon as a financial loss. The passage goes on to say that if complications occur, so that the woman loses her life as a result of the miscarriage, then the man causing the injury will pay with his life. The rest of the passage is very familiar: an eye for an eye, tooth for tooth, hand for hand, etc. This Mosaic Law which does not reckon the fetus as equivalent to a life is even more significant when considered in contrast to a similar Assyrian Law of the same era which required a life for the loss of a fetus.

Despite varying opinions concerning when the developing embryo or fetus is to be considered a human with a soul, the potential great value of the developing intrauterine life cannot be denied. The early human gestation is not merely a mass of cells or an organic growth. At the most, it is an actual human life or at the least, a potential and developing human life. Therefore induced abortion should be recommended with caution in order to safeguard greater values sanctioned by Scripture including individual health, family welfare, and social responsibility. Suitable cases would fall within the scope of the recommendations of the AMA or the ACOG. Changes in state law that would permit honesty in the application of established criteria should be encouraged provided they protect the physician from legal action or medical liability should he refuse to perform the operation because he finds a particular abortion to be against his moral standards.

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Radium And The Physician

Information for physicians concerned about radium hazards is graphically summarized in a new publication of the U.S. Bureau of Disease Prevention and Environmental Control. Entitled *Radium and the Physician,* the pamphlet contains text and illustrations which review basic facts about radium. The extent of usage, shielding requirements, source leakage, and radiotoxicity are included, along with problems of handling, storage, radioactive contamination, and loss of sources.

Methods of minimizing radium radiation hazards by alternate types of treatment, radiation protection safety surveys, and radioactive contamination insurance are also covered.

Single copies may be obtained gratis (P.H.S. Publication #1698) from the Radiologic Health Program, P.O. Box 1540, Trenton 08625.

No Fee—No Report?

May a consulting physician withhold the results of his examination of a patient who has been referred to him until his fee for the consultation has been paid? No, he may not. In November 1968, the AMA Judicial Council said that as soon as possible after the consulting physician has seen the patient, he should advise the referring physician of the results of his investigation.

The interest of the patient is paramount in the practice of medicine. Therefore, everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient.

The Judicial Council affirms that it would be improper and unethical for a consulting physician to withhold the results of his examination until his invoice has been paid.

A 24 year survival period after removal of a malignant melanoma is an amazing duration. In this case, the metatasis led to melena.

Melena: Secondary To Malignant Melanoma*

A Case Report

William E. Ryan, M.D.;
William E. Topley, M.D.;
John F. Kustrup, Sr. M.D.;
and Abbas Yazdi, M.D./Trenton

Gastrointestinal bleeding in a patient with a previously removed melanoma (regardless of length of time following surgery) should alert the clinician to the possibility of gastrointestinal metastasis. In this instance a patient with a twenty-four year survival of a melanoma removed from the neck presented with melena. Her case report is summarized as follows:

A 65-year-old female was admitted to St. Francis Hospital for the first time on October 27, 1966, because of marked anemia. She had been first seen four and one-half weeks prior to her admission because of acute bilateral thrombophlebitis. After other conservative measures had failed, the patient had been placed on phenylbutazone-Alka® for ten days prior to admission. She complained of fatigue and epigastric distress immediately prior to her admission.

She had had a "lump" excised from the left side of the neck in 1944 and again in 1945. Correspondence from her surgeon revealed that she had undergone wide and deep excision of a malignant melanoma of the supra scapular region in 1944. This surgery was followed by a supra-clavicular lymph node dissection 18 months later for recurrence in a lymph node adjacent to her primary site. She was followed regularly without evidence of recurrence. She had had a cholecystectomy for cholecystitis and cholelithiasis and appendectomy forty years previously.

On admission she appeared pale, but was not in acute distress. A well-healed left suprascapular surgical scar was evident. Lungs were clear. The heart evidenced a regular sinus tachycardia, but was otherwise unremarkable. There was no organopathy. In the lower extremities, she had several areas of superficial acute thrombophlebitis. Hemoglobin was 6.5 Grams; hematocrit 22; leukocyte count 5,650 with normal differential. Her peripheral blood smear revealed some hypochromia and anisocytosis. Stools were positive for occult blood. Serum iron was 81.5 mcg. Blood sugar, urea nitrogen, and other serum chemistries were within normal limits. A gastrointestinal x-ray series disclosed an acute ulcer of the duodenal bulb. Chest x-ray revealed a spherical mass measuring 45 millimeters in diameter in the posterior right lung sulcus compatible with a neoplastic lesion.

It was felt that the patient's acute problem was gastrointestinal bleeding, secondary to peptic ulceration, possibly associated with ingestion of phenylbutazone. This drug was withdrawn, and she received three units of blood. She responded well to bland diet and antacid and anti-cholinergic therapy. She was given a course of Imferon® therapy.

The patient refused surgical diagnostic suggestions toward ascertaining the nature of her right lung lesion. She was discharged from the hospital on November 7, 1966.

Interim chest x-ray in December, 1966, indicated no change in her pulmonary lesion, and a hemogram then disclosed a slight improvement of her anemia.

In January, 1967, the patient noted recurrent fatigue and epigastric distress. Blood count disclosed return of the anemia. Her stools again became positive for occult blood. She was readmitted to St. Francis Hospital with a diagnosis of recurrent bleeding duodenal ulcer. Her phlebitis had cleared. There were no new physical findings.

She now had a hemoglobin of 9.1; hematocrit 31; leucocyte count of 9,700 with a normal differential. Stools were positive for occult blood on seven occasions. Gastrointestinal series were normal and disclosed no evidence of the previously noted duodenal ulcer. All other laboratory studies were normal. Chest x-ray told us that the pulmonary mass in the right lower lung had not changed in size or characteristics. At bronchosocopy, there was no evidence of endobronchial neoplasm.

On February 14, 1967, the patient suffered another gastrointestinal hemorrhage. Small bowel study disclosed a one-centimeter round filling defect of the jejunum and alteration in the caliber and mucosa of irregular nature. This involved a three-centimeter segment of ileum.

The patient underwent laporotomy one week later. On

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opening the abdomen, a metastatic lesion was noted on the greater omentum. Two metastatic lesions were present on the small bowel mesentery. There was an indurated, pigmented lesion in the small bowel lumen, eighteen inches proximal to the ileocecal valve. Three other lesions of about three-centimeters in diameter were in the ileum, and it was presumed that these tumors were the source of bleeding. Other lesions were noted in the jejunum, starting two inches distal to the ligament of Treitz. There were one to three centimeter variegated and pedunculated lesions throughout the jejunum. These lesions histologically represented metastatic melanotic melanoma, showing extensive ulceration of the lumenal surface. (See Fig. 1, 2, 3, & 4). No evidence of duodenal ulcer was noted at surgery.



Figure 1
Gross Specimen — Terminal Ileum

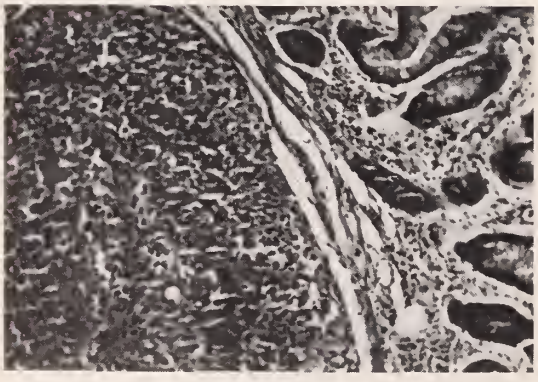


Figure 2
Melanoma in Submucosa of Small Intestine

Small bowel resection, therefore, was purely palliative; and a decision was made to institute chemotherapy when timely. She was well enough to be discharged on March 4, but was readmitted on April 11, with abdominal pain, persistent vomiting, dehydration, and evidence of recurrent bleeding. Because of the extensive nature of her disease, only supportive therapy was given, she died on April 24, 1967. An autopsy was not obtained.

This patient presents interesting and illustrative features of malignant melanoma. Recurrence after twenty-four years is rare and noteworthy. Initially, she had deep and wide excision of her primary lesion, which was followed by supraclavicular lymph node dissection nineteen months later. An aggressive surgical approach in both instances surely allowed this patient a long interval of freedom from recurrence and underscores the need for a vigorous, early approach to melanoma treatment.

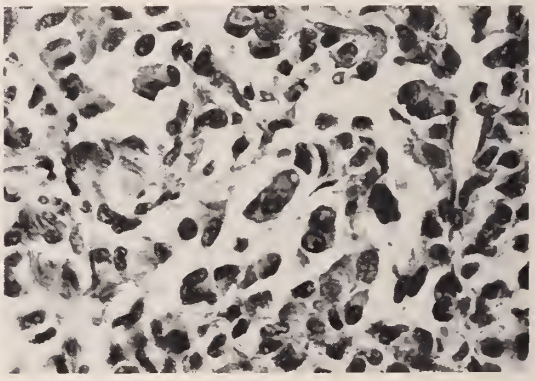


Figure 3
Tumor in Small Intestine

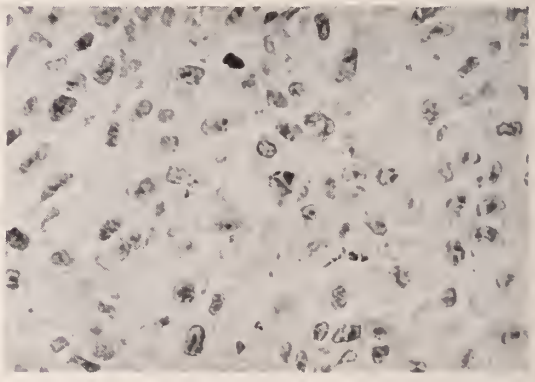


Figure 4
Melanin Granules — Tumor Stain

She showed two distinct causes for her melena which confronted us with a vexing problem in differential diagnoses. In the first instance, she had roentgenologically demonstrated duodenal ulcer, which for a time obscured the more ominous melena related to the ulcera-

tive small bowel lesion secondary to malignant melanoma.

Bockus[1] points out that melanoma is rarely a primary lesion in the small bowel, but it is ordinarily secondary to cutaneous melanoma or melanoma of the colon and rectum.

Several authors, including Willis,[2] have pointed out that it is not unusual for metastatic melanoma to involve small intestines. In his autopsy series of 135 cases of tumor with hematogenous metastasis to small bowel, 45 were from malignant melanoma, making it the most commonly metastasizing lesion to small bowel.

According to Willis,[2] early hematogenous spread first involves the submucosa and produces a pedunculated mass projecting into the lumen. The mucosa or muscularis is secondarily involved. Polypoid, nodular, and ulcerative lesions may be seen on x-ray series. Metastasis, even if known, often cannot be demonstrated by x-ray. This initially was the case with our patient.

Dasgupta and Brosfield[3] reviewed one thousand cases of cutaneous melanoma in which nine had intestinal or gastric metastasis, confirmed by autopsy. The stomach and small bowel are areas most commonly involved, with the colon next in frequency. They found that metastatic lesions to the small bowel from melanoma may produce encroachment on the small bowel lumen with obstruction or intussusception and may erode mucosa to produce upper gastro-intestinal hemorrhage. In our patient, ulceration with bleeding was first observed, but obstruction of the small bowel was felt to contribute to her demise.

Dasgupta and Brosfield[4] reviewed a large series of cases of melanoma with metastasis treated at Memorial Hospital in New York between 1935 and 1960. Although ante-mortem diagnosis has not been frequent, they point out that metastatic melanoma to the small bowel is a common autopsy finding. In their series of 652 patients, 125 came to autopsy. Small intestine was involved in 58 per cent of the cases, stomach in 26 per cent, colon and cecum in 22 per cent, and duodenum in 12 per cent. Extremes of the GI tract were rarely involved. Therefore, occult blood in the stool of the patient with known primary malignant melanoma should suggest gastric or intestinal metastasis to the clinician.

In reviewing a case of melanoma with metastasis, Haskin[5] noted that the small bowel x-ray appearance is usually that of an intramural extra-mucosal defect or a polypoid defect. Rarely is there complete annular construction. Other sources of hematogenous spread of tumor to the small bowel were from the lung, breast, choriocarcinoma, kidney, and stomach.

Nodular lesions in the small bowel should suggest the diagnosis of melanoma, Kaposi carcinoma or Peutz-Jegher syndrome, and when the lesions are smaller and distributed throughout the small bowl, systemic mastocytosis and lymphosarcoma.

Summary

A 65-year-old female with gastrointestinal bleeding had a metastatic melanoma of the small bowel. The primary lesion had been removed from her left neck twenty-four years previously, which represented a remarkable period of survival. This case illustrates the value of vigorous, early surgical approach. The clinician should be alerted to the possibility of gastrointestinal metastasis when bleeding occurs following the removal of melanoma.

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Granulomatous disease of the colon is a distinct entity to be distinguished from ulcerative colitis on clinical, radiologic, and pathological grounds.

Granulomatous Colitis*

Victor W. Groisser, M.D./Montclair

In the past, granulomatous colitis was usually mis-diagnosed and considered to be ulcerative colitis. We now realize that these are two separate entities which can be distinguished on clinical, radiologic, and pathological grounds.

What is Granulomatous Colitis?

It is a transmural disease involving the full thickness of the colonic wall from mucosa to serosa. It is most often a discontinuous process with normal intervening areas of bowel. It frequently is associated with granulomatous disease of the ileum, both showing the same pathologic findings. In contrast, ulcerative colitis is basically a mucosal disease which involves continuous areas of the colon.

Granulomatous colitis has often been called segmental colitis, transmural colitis or Crohn's disease of the colon. When regional enteritis is associated with colonic inflammatory disease, the term "granulomatous ileo-colitis" is often used.

How has the concept of granulomatous colitis evolved as a distinct entity?

In 1932, Crohn *et al.*[7] described a non-caseating granulomatous process involving the distal ileum. Heretofore this process had been considered to be tuberculous in nature. In 1934 a case of colitis was described as being granulomatous by Colp.[8] This interpretation, however, was not particularly noted by the medical profession. Instead, whenever non-bacterial and non-parasitic inflammatory large bowel disease was diagnosed, it was generally thought to be ulcerative colitis. When granulomatous enteritis (regional enteritis) was found associated with colonic inflammatory disease, the colonic process was again thought to represent ulcerative colitis.

In the 1950's, Wells[9] and Brooke[10] described some of the features of granulomatous colitis. Wolf and Marshak[11] described the radiologic changes in the colon in this disease. In the years 1960 to 1967, further differentiation of granulomatous colitis from ulcerative colitis was made on clinical, pathological, and radiologic grounds by Lockhart-Mummary and Morson,[1,3] Lindner et al.,[2] Marshak et al.,[4] Janowitz and Present,[5] and G. Jones *et al.*[6]

Slowly, as physicians realize they can differentiate granulomatous from ulcerative colitis, the diagnosis of the former is being made more frequently. Thus, physicians who are seeing large numbers of these diseases are finding that as many as 50 per cent of the cases heretofore diagnosed as ulcerative colitis are now better diagnosed as granulomatous disease of the colon.

What are the pathologic features which distinguish granulomatous from ulcerative colitis?

Granulomatous colitis is a transmural process. It starts in the sub-mucosa and involves the mucosa, muscular layer, and serosa. The mesentery, peri-colonic fat, and adjacent lymph nodes are often involved. Fibrosis as a consequence of proliferation of collagen tissue is an important element.

* Read before the Joint Session on Gastroenterology and Proctology and General Practice, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1969. Dr. Groisser is director of gastroenterology at Mountainside Hospital in Montclair.

The non-caseating granulomas consisting of epithelioid and Langhan's giant cells are prominent features. Another important finding is the presence of lateral fissures which extend from the mucosa through the sub-mucosa and often into the muscularis and serosa. Further extension of these fissures may produce fistulae. The disease is usually discontinuous and one will find completely normal areas of bowel interspersed with involved sections of the colon. The transmural involvement, the granuloma, the finding of intervening normal tissue, and the lateral fissures clearly distinguish this process from ulcerative colitis. In the latter, the process is generally limited to the mucosa. (Only occasionally is the submucosa involved.) The process is continuous and granulomata are not to be found.

Not *all* of the above features are observed in granulomatous colitis. If the colon is carefully sectioned, however, most of these findings will be present. In some series, granulomas have been found in only 30 to 40 per cent of cases, but where serial sections have been taken and the lymph nodes examined as well as the colonic tissue, an incidence of 80 per cent finding of granulomas has been noted.

What is the etiology of granulomatous disease of the small and large bowel?

One theory projected by a number of investigators[5] is that some toxic lipoid substance (perhaps a lipoprotein) gains entry into the lymphoid tissue in the sub-mucosa of the bowel, causing reactive fibrosis and granulomata formation with lymphatic blockage and other pathologic consequences.

What clinical features distinguish granulomatous from ulcerative colitis?

As in ulcerative colitis, diarrhea is the most frequent clinical symptom. But bloody diarrhea is much less common in granulomatous disease. Mild obstructive symptoms may be present consisting of cramping or colicky abdominal pain. Weight loss, fever, anorexia, and lethargy may be noted in both conditions. Fistulization to the skin, to adjacent loops of small or large bowel, and anal lesions are frequent concomitants of the granulomatous process. Fistulae are uncommon in ulcerative colitis, which at times may show recto-vaginal fistulae, or anal fistulae as a consequence of the breakdown of rectal abscesses.

Anal lesions (anal ulcers, fissures, and fistulae) are frequent in granulomatous colitis and in a number of cases often precede the development of the full-blown granulomatous colitis. Many patients are operated upon for some form of anal lesion only to have granulomatous colitis diagnosed years later.

Physical findings do not help separate the diseases unless a mass is felt — particularly in the right lower quadrant or along the thickened bowel. This is in keeping with the diagnosis of granulomatous disease. The bowel is not palpable in ulcerative colitis unless carcinoma is present.

Complications of the disease such as toxic megacolon and carcinoma of the colon are more frequent in ulcerative colitis. Extra colonic manifestations including arthritis and iritis are more common in ulcerative colitis and erythema nodosum is perhaps more common in granulomatous disease. Amyloid disease is more frequently associated with granulomatous disease.

How do we establish the diagnosis of granulomatous colitis as distinguished from ulcerative colitis?

In 80 to 90 per cent of cases, the diagnosis can be established on clinical, radiologic, and pathologic grounds. The two most useful nonsurgical measures are sigmoidoscopy and biopsy, and radiologic evaluation. If indicated, surgery will afford the final diagnostic proof and in perhaps 10 per cent of cases will establish an otherwise insecure diagnosis.

Sigmoidoscopy

In ulcerative colitis, the rectum is involved in from 95 to 100 per cent of cases. The mucosa in the active patient is granular and friable with some mucus or pus. In 50 per cent or fewer of the cases of granulomatous colitis,

the rectum will show macroscopic changes on sigmoidoscopy. These may vary from changes indistinguishable from ulcerative proctitis to changes in which edema and cobblestone formation predominate.

In all cases of inflammatory bowel disease a biopsy should be taken. If the biopsy shows granuloma in the mucosa or sub-mucosa a definite diagnosis of granulomatous colitis is made. This may be found in about one fourth of the cases.

The finding of a normal rectal mucosa, macroscopically and by biopsy, should suggest that the inflammatory bowel disease is granulomatous in nature.

The clinician should also make certain that the pathologist examines any anal tissue which may have been removed previously. Granulomata are often discovered in this tissue taken from patients who are later diagnosed as having granulomatous colitis.

X-ray examination

Perhaps the most helpful means of making the diagnosis is by radiologic examination of the large and small bowel.

If small bowel granulomatous disease is diagnosed by x-ray it is almost a *sine qua non* that the associated colonic inflammatory disease is of the granulomatous variety.

Although granulomatous colitis may involve the entire colon in some patients, it is usually segmental in distribution with intervening areas of normal bowel. Right-sided involvement of the colon is usually indicative of granulomatous disease. The rectum is involved in perhaps 50 per cent or less. Occasionally, only the sigmoid and rectum are noted to be affected in granulomatous disease.

The significant findings on barium enema examination in granulomatous colitis include its segmental distribution, the appearance of strictures when present, the presence of pseudo-diverticulae, asymmetric involvement of the bowel wall in the involved segments, the presence of longitudinal ulcerations and transverse fissures, and the finding of fistulae when present.

What is the therapy of granulomatous colitis?

We are limited in our therapeutic approach. This is a chronic and persisting process. In some series, 60 to 80 per cent of patients have required surgery.

Medical treatment should be supportive in nature with a nutritious diet, vitamin supplementation if needed, and provision for rest. Antidiarrheal medication and antispasmodics should be used as indicated. Non-absorbable sulfas, such as Azulfidine®, may be tried. This medication, which is in part a salicylate, is taken up by the connective tissue of the gut. Response to this medication is only spotty, however.

Steroids may be of value in ameliorating disturbing symptoms and in helping the patient to live with his disease during the more difficult periods. But steroids, at least as used presently, do not seem to change the overall course or prognosis of the disease. If steroids are used, Prednisolone®, in doses of 30 to 60 mgms, is a useful initial dosage range — the dose level then being tapered consistent with the patient's progress. ACTH and steroid enemas have also been utilized in this disease with some limited success.

Surgery is reserved for patients who develop complications such as abscess formation, obstruction, massive bleeding, fistulization, and for the patient whose disease is debilitating. A large majority of patients will eventually require surgical intervention.

At the moment, the two most beneficial surgical procedures seem to be limited resection of the colon when the disease is localized to one or more segments and to total colectomy with ileostomy when there is peri-anal involvement and/or diffuse disease. Ileo-proctostomy has been tried where rectal disease is absent, with inconstant results.

Recurrences, when they have occurred, are noted in the distal ileum or distal to the site of colonic anastomosis.

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21 Plymouth Street

The Healthy School Environment

Few people are aware of the favorable as well as unfavorable effects that environment can produce on a student's ability to absorb knowledge. However, a new book, entitled *Healthful School Environment,* arms the reader with factual information on the vital role played by environment in the growth and development of school children. Co-edited by Elizabeth Avery Wilson, Ph.D., and Charles Wilson, M.D., this is a completely revised edition of the former *Healthful School Living,* produced in 1957. Here many facets of healthful school environment are explored in detail: "School Organization and Pupil Health," "Emotional Setting of the Classroom," "Promoting Safe Living in School," "School Food Services," and "The School Administrator and the Environment."

Healthful School Environment, published jointly by the American Medical Association and the National Education Association, is available in both a hardbound and paperback edition. Inquiries concerning *Healthful School Environment* should be directed to the AMA Order Handling Unit, 535 North Dearborn Street, Chicago, Illinois 60610.

Punch Drunk: Myth Or Menace

In 1928, Harrison S. Martland, M.D., described a syndrome in prize fighters who were frequently knocked out. He called it "punch drunk" and said it was due to multiple petechial hemorrhages. However, Dr. Harry A. Kaplan, Professor of Neurosurgery at the New Jersey College of Medicine, says that this is a myth. Dr. Ira McCown, medical director of New York's Athletic Commission, said that he found significant medical disability in only 148 out of 11,000 boxers examined by the Commission. Dr. Kaplan, who had been a ringside physician for some years, examined 4,800 electroencephalograms of boxers and found no changes in the tracings just after a boxer had been defeated in the ring. Dr. Milton Helpern, New York City's chief medical examiner finds edema of the brain as the most common finding after a boxer takes a severe head beating. "When burr holes were made in the skulls of fighters who had been knocked out, brain tissue oozed out like toothpaste from a tube." All observers agree, however, that any boxer who is knocked out should be out of the ring for at least thirty days.

—*Image and Commentary,* Roche Laboratories, Nutley, New Jersey, August 1969 issue, page 14.

In depth psychological tests can serve a therapeutic as well as a diagnostic function.

Use Of Test Findings In Marital Group Therapy*

Kenneth K. Berman, M.D.
and Louis Boxer, Ph.D./East Orange

What are the specific personality traits of a wife whose husband is in a psychiatric installation? And how can the therapist exploit the psychologic test findings in connection with conjoint marital group therapy sessions? To answer these two questions, this study was developed.

Groups of four or five married couples participated in twice-a-week group therapy sessions under the leadership of the senior author. The sessions were of ninety-minute duration. Psychotherapy was usually for a two to four month period. The groups were composed of psychiatrically hospitalized veterans and their non-hospitalized wives. None of the patients or their wives had been hospitalized for a psychiatric disorder *prior* to marriage. Specific personality patterns of the husband were compared with those of the non-hospitalized spouse to determine whether significant differences existed between the partners. These variables ranged from dominance to dependency, from narcissism to sadism and masochism. We evaluated ego synthesis, stress tolerance, regression in the service of the ego, and defense mechanisms. Superego-variables showing levels of moralistic thinking and superego-conflict were evaluated by utilizing the Grunes scale of Conscience[1].

The psychologic test battery consisted of projective-expressive technics†. As controls, the same battery was administered to two control groups. One group consisted of *medically* hospitalized patients and their non-hospitalized wives. No one in this medical control group had a history of psychiatric hospitalization. The second control group consisted of "normal" couples, i.e., non-hospitalized subjects without any history of psychiatric hospitalization. There were twenty couples in each group (N-120). Subjects were equated as well as possible for education, I.Q., age-range, and social, cultural, and educational background.

The completed test batteries of all subjects were evaluated by the co-author (Dr. Boxer) and two other rater-psychologists equated for training and experience. We utilized Prelinger's Assessment Scale[3] which carefully delineated (on a graduated rating scale) the ego variables and personality elaborations outlined above. The inter-rater correlation of the three judges reached a sigificant level of agreement, indicating that the reliability attained in the test findings was in agreement with similarly positive reliability studies reported by Prelinger and Zimet.[2]

Prior to entering conjoint group therapy, the test-findings of each of the married couples in the psychiatric group were summarized in a report emphasizing the similarities and dissimilarities of personality patterns of each. The senior author then selected specific material elicited from these reports, and at appropriate times, would introduce this material

* This is based on an expansion of a thesis jointly prepared by Dr. Berman and Dr. Boxer in partial fulfillment of the Ph.D. requirements of Yeshiva University in New York City. The marital partners here were all males hospitalized in the Veterans Administration Hospital in East Orange, New Jersey.

† The test battery consisted of projective drawings, Adjective Check List, I.Q. test, Sentence Completion Test, and the Grunes Scale of Conscience.

for group discussion. The material generally focused on areas or findings that had not previously been discussed in the group therapy sessions. Comments and feeling from the involved couple regarding these findings were encouraged. The other group members were then invited to share their thoughts and feelings in regard to the findings dealing with the specific couple.

Results

I. Psychologic test-findings:

a. When marital partners in this study were markedly dissimilar and one of the partners was rated as having "maladaptiveness of ego functioning"** the partner with the maladaptive ego functioning was usually the one hospitalized; whereas, the partner rated as being more ego adaptive was less likely to need psychiatric hospitalization. Conversely, when the marital partners were rated as being significantly congruent in their personality patterns, neither partner required psychiatric hospitalization.

b. When there was significant disagreement in one's self concept and the way his spouse perceived him and when one of the partners had maladaptive ego functioning, the maladaptive partner was more likely to be psychiatrically hospitalized. Conversely, when there was significant self-spouse congruence of concept, neither partner was likely to be hospitalized.

c. The marital partners in the experimental (psychiatric) group showed a significant disparity between them on their scale scores for superego development. That is, the patients in the psychiatric group obtained scores showing higher superego conflict than their wives. The partners in the normal control group showed significantly less superego conflict than the couples in other groups.

d. Test protocols frequently indicated areas of conflict between the marital partners in the psychiatric group which had not been introduced or exposed previously in the therapy sessions. The findings then served as a catalytic agent in working through important areas of conflict between partners. There was a springboard for working through feelings of ambivalence and disharmony. The Sentence Completion Test and the Adjective Check list often opened up critical areas of conflict since the responses often revealed attitudes and perceptions that the mates had previously suppressed from each other. When these conflicts were focused upon during the therapy sessions, it frequently served as an effective way of enabling the partners to ventilate their feelings and to obtain a better understanding of their conflicts.

II. Group therapy findings:

a. In a number of instances, subjects showed ambivalence and conflict in accepting the test findings. This was then either worked through or the specific discussion was dropped.

b. In a significant number of instances material elicited from the psychologic battery had not been previously raised or ventilated in the group sessions. These findings were then used in the group sessions to facilitate the working through of specific conflicts. These findings frequently served as a catalyst in permitting suppressed material to emerge. It also encouraged a lively interaction between the group members and permitted them to identify and empathize with each other. Supportive feeling between the group members was elicited as they experienced the sharing of similar conflicts.

c. Material which might have been omitted, glossed over, or avoided in the therapy sessions was elicited and pin-pointed from the psychologic battery. This was especially evident in the Sentence Completion Test, as well as in the Adjective Check List, which suggested areas of conflict between mates which had not been expressed during the therapy sessions. In a significant number of cases in the psychiatric group, the partners themselves were unaware of the incongruence and disagreement in their self-spouse perceptions.

** "Maladaptiveness of ego functioning" indicated low scores, i.e., poor adaptation, ego synthesis, stress tolerance, regression in the service of the ego, and defense mechanisms.

These incongruences and misperceptions were then ventilated and explored during the sessions.

Discussion

I. Psychologic test findings:

Experimental (Psychiatric) group—The men (patients) in this group were generally quite divergent from their wives in personality patterns and ego structure. The husbands were appraised by all three judges as having high dependency-needs which they desperately tried to deny; they were rated as having maladaptiveness of ego functioning; they tended to be moralistic but showed severe superego conflict; they were evaluated as highly narcissistic. The overall picture of these patients was one of overwhelming ambivalence. The basic conflict generally seemed to center around dependency needs and the inability to accept these needs. Masochistic trends were also evident in these patients.

The personality patterns of their wives, however, were significantly different. The wife was generally evaluated as a driving, dominating woman who had deep nurturance needs. This marital union of the dependent male who could not accept his dependency needs with a driving, dominating but ambivalent female often led to a sort of *folie a deux*. The wife showed significantly higher ego adaptiveness; had a somewhat higher moralistic superego, but showed significantly less superego conflict. Her moralistic thinking tended to be self righteous, and unlike her husband, she was generally successful in sublimating and repressing conflicting drives. In regard to self-spouse congruence of concept, partners in this experimental group showed significantly more incongruence than the partners in the normal group. When they did show any congruence or agreement it was frequently on negative concepts, rather then positive. The marital union appeared to be characterized by hostility, conflict, and dissatisfaction. The clinical impression was that although these marriages were formed because of powerful, unconscious needs, the particular dissimilarities between them tended to intensify an already unstable equilibrium.

Normal control group—The normal group manifested significantly higher adaptiveness of ego functioning than all other subjects. They had higher self-spouse congruence of concept; that is, there was consistently higher self-spouse agreement on positive factors; there was less negative criticism; there was a consistent rating of congruency or similarity of personality patterns between partners which was frequently absent in the couples within the psychiatric group. Although there was generally this congruence (even where there was a divergence of personality patterns) it tended to be complementary rather than destructive to the marital relationship, i.e., the partners viewed their personality differences in positive and satisfying concepts.

The partners on this normal group were rated as being less dependent, narcissistic, sadistic, or masochistic. Levels of moralistic conscience were not significantly different from the others, but superego conflict was considerably less than the patients in the experimental group, and generally at lower levels than those of all the other subjects. The overall clinical impression was that the marital partners in this group presented a consistently higher level of adequate functioning on practically all the variables involved in this study.

II. Group therapy findings:

Use of the test findings played a significant role in conjoint marital therapy. Specific material elicited from the protocols, served as a natural catalyst in exploring conflicts, hostilities, and misconceptions that the marital partners had not brought out into the open in previous sessions. It brought to light definite attitudes, concepts, and impressions that some of the partners had about their spouse of which the other partner had not previously been aware. Conflicts which had been repressed (or had been deliberately kept suppressed) were brought out into the open when the therapist thought the time was opportune. Each of the psychologic tests seemed to serve a unique purpose in working through some of the marital conflicts. To illustrate, the Adjective Check List completed by the partners in the psychological (experimental) group

showed significant incongruence in the self-spouse concept, i.e., there was significant disagreement in the subject's self concept and the way that his spouse perceived him. Frequently, when this self-spouse incongruence was brought to light in the therapeutic session, it was a startling insight to the partner involved. Exposure of these contradictory perceptions stimulated intensive working-through of these misconceptions. Often, the material elicited from the psychologic protocols would reveal conflicts that had not been brought up in previous therapeutic sessions. Sometimes this was graphically illustrated in the Sentence Completion Test. For example, one patient who was consistently dominated and overwhelmed by his wife but who had never confronted his wife with his resentment, wrote on the Sentence Completion Test, "A man should *be the king of his castle!*"

Another illustration was that of a woman, who was outwardly attractive, feminine, and seductive, wrote, "At night I dream *of being a man!*"

Another significant finding was the clear contrast between attitudes and feelings of the subjects toward their parents, particularly, their fathers. This conflict between the subjects and their attitudes toward their fathers was obtained primarily from the Sentence Completion test which included a measurement of attitude toward parents. The majority of the male patients in the psychiatric group expressed hostiliy toward their fathers. In the protocols of the subjects in the normal group, however, there was very little evidence of overt hostility or dissatisfaction toward the father. On the contrary, the Sentence Completion Test generally evoked positive comments in regard to both parents. In working with the patients in the psychiatric group, the negative and hostile reactions of the patients toward the father served as an important catalytic agent in the conjoint group therapy sessions. It enabled the therapist to focus on this crucial area of conflict between father and son. As a result, the ventilation and working through of their ambivalent feelings toward the father was facilitated.

A highly significant finding in the use of the test protocols in the psychiatric group therapy sessions was the striking corroboration of a persistent clinical impression observed in the therapy sessions. The observed picture was that the wife was frequently evaluated as a dominating, driving woman who also had deep nurturance needs; whereas, the husband was perceived as an insecure, dependent male who could not accept his dependence needs. This clinical impression obtained in the therapy sessions was significantly supported by the clinical-psychologic protocols. The projective drawings and the Sentence Completion Tests were especially helpful in highlighting this particular syndrome.

Summary

The psychologic test battery in this study served a dual purpose: to uncover, elicit, and pinpoint specific conflicts between marital partners; and this, subsequently helped the marital partners to ventilate, explore, and work-through these areas in conjoint group therapy. Then, too, test findings played a significant role in helping to validate the clinical impressions obtained from the therapeutic group sessions. Tentative conclusions that were drawn from the therapy sessions could then be compared to the psychologic findings to obtain a higher degree of validity.

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Veterans Administration Hospital

Most effective way of reconstructing hearing mechanisms is "intact wall mastoidectomy." This maintains a middle ear cavity of normal depth.

Methods And Results Of Tympanoplasty*

Isadore M. Schnee, M.D./Paterson

The initial enthusiasm in tympanoplasty was dampened by poor results in long term follow up. Careful preoperative evaluation, adequate preparation, technical improvements, better grafting material and ossicular substitutes, and doing the surgery in two stages have contributed toward better results.

Objectives in reconstructive surgery of the middle ear are:

1. Eliminate infection
   a. In the middle ear (tympanotomy)
   b. In the mastoid (mastoidectomy)

2. Reconstruction of hearing mechanism
   a. The ear drum (myringoplasty)
   b. The ossicles (ossiculoplasty)

Mastoid surgery for chronic ear disease as practiced for years, whether radical or modified, implied the creation of a cavity or "mastoid bowl" which opens into the external auditory canal. This cavity requires lifetime care and precautions with respect to activities that entail water entering the ear and is subject to reinfection. Furthermore, due to the removal of the posterior canal wall, the ear drum cannot be reconstructed in its normal position at the level of the annulus. Instead, the reconstructed drum is lowered to the stapes, resulting in a small cavity with inferior functional improvement.

In the system of tympanoplasty employed in the cases reported, an attempt is made to maintain intact the canal wall but not at the expense of thorough surgical debridement.

Five types of tympanoplasty are based on ossicular reconstruction. They are as follows:

Type I. The ossicles are intact and mobile.

Type II. The incudostapedial defect is repaired by repositioning of ossicle or wire prosthesis.

Type III. The malleus is absent or not usable, the drum is lowered to the stapes or a plastic prosthesis is placed between drum and stapes.

Type IV. The footplate is exposed to sound pressure and the rest of the middle ear is enclosed in a small cavity.

Type V. The lateral semicircular canal is fenestrated.

Type IV and V are rarely done now.

Systematic Technic Used In The Cases Reported.[1,2,3,4,5]

1. Transmeatal Tympanotomy and Myringoplasty

The pathology that is accessible through the tympanic membrane perforation is removed. The drum is prepared for the reception of a graft by stripping the deep marginal mucosa in a small perforation, using a vein graft. In a large perforation, the superficial epthelial layer is stripped and fascia is used for grafting. The middle ear is then explored through a stapes type of incision and the pathology removed. When the ossicular chain is intact and mobile and there is no evidence of mastoid disease, the tympanomeatal flap is replaced and the drum is grafted with vein or fascia as indicated. This Type I tympanoplasty yields the best results.

* Read before the Section on Otolaryngology; Annual Meeting of The Medical Society of New Jersey Atlantic City, May 19, 1969. Dr. Schnee is Chairman of Otolaryngology at Barnert Memorial Hospital Paterson.

2. Ossiculoplasty

The most common defect is incus necrosis. The incus is removed and repositioned between the malleus and the mobile stapes. When the stapes is fixed, a stapedectomy is done at a second stage using a wire from malleus to oval window. When the incus is not available or usable, a wire is placed between malleus and stapes. These are type II reconstructions. The results in this type are not as good as type I but superior to type III.

3. Atticotomy

When the pathology is limited to the attic, it is removed as well as the head of malleus and the incus is repositioned for a type II.

4. Mastoidectomy

When there is mastoid disease beyond the attic, especially cholesteatoma, a mastoidectomy is done through a postauricular incision, preserving the posterior wall of the external auditory canal when possible, thus avoiding the formation of a mastoid bowl and what is equally important, rendering possible a type II reconstruction. In this technic, the mastoid aspect of the bony canal is drilled extremely thin and the facial triangle is dissected to obtain a good view of the middle ear from behind. A modification of this procedure which makes it possible to preserve the posterior canal wall in a greater number of cases is called the osteoplastic mastoidectomy. (Figures 1 and 2) It consists of sectioning the posterior bony wall superiorly and inferiorly, moving it forward to obtain a more adequate exposure of the pathology. The bone remains attached to the skin and is replaced in normal position. Finally, if and when, in spite of all efforts to preserve the canal wall, it must be taken down, the mastoid bowl is grafted in continuity with the denuded drum with a large split skin graft taken from the abdomen.[6] When the bridge is left intact and the malleus is usable, a type II reconstruction can be done, otherwise, a type III is done by lowering the graft to the stapes.

We had 232 cases performed with the system described. These were done between 1960 and 1967. Each was observed for at least two years. Of these, 62 had type I reconstruction. One year after surgery, 54 of these (85 per cent) had a reduction in the air-bone gap to 20 decibels or less, predominantly 10 decibels or less. We had 148 in type II. Of these 112 (76 per cent) showed reduction of air-bone gap to 20 decibels or less, predominantly above 10 decibels. In type III, we had 22. Of these, 10 (46 per cent) resulted in air-bone gap reduction to 20 decibels or less with none reaching the 10 level.

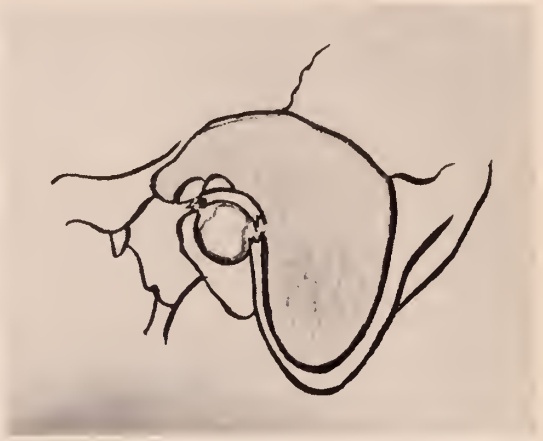


Figure 1 — Superior and inferior osteotomies of posterior bony canal wall, in osteoplastic mastoidectomy



Figure 2 — Posterior canal wall mobilized forward, in osteoplastic mastoidectomy

At two years, postoperatively, there was about a 25 per cent regression, mostly in type II cases. About half of the type II cases were done in two stages.

About 30 per cent of cases of all types were revised prior to one year postoperatively. We did not include in these statistics, cases where reconstruction of the hearing mechanism was not done or completed.

Summary

1. Intact canal wall mastoidectomy is conducive to a more effective type of hearing mechanism reconstruction as it maintains a middle ear cavity of normal depth.

2. Osteoplastic mastoidectomy enables the preservation of the posterior canal wall in a larger number of cases.

3. Reported here are 232 cases of tympanoplasty with results at one and two years postoperatively.

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625 Broadway

Family Medicine As Primary Specialty

Family Medicine was "officially" recognized in February by the Advisory Board for Medical Specialties and the Council on Medical Education of the American Medical Association. This is the twentieth of our profession's primary specialty groups. It brings medicine full-circle since the trend toward specialization began in the late 1940s. Before that, most doctors were GPs. With creation of the specialty of "Family Medicine" the GP now can become a "specialist" in his own right.

And American Board of Family Practice is now empowered to conduct examinations and to grant specialty certification to physicians who meet its qualifications and pass the examination. This certification will be recognized by the American Medical Association and other regulative bodies in medicine. This, it is hoped, will increase the attractiveness of primary medical practice to young doctors. A basic problem in health care has been a shortage of physicians to serve as first-line doctors.

Family doctors now in practice will be eligible to take the examination upon evidence of having completed 300 hours of accredited graduate study in medicine. In most cases, this would mean having been a member of the Academy of General Practice for six years. The AAGP requires its 31,000 members to complete 150 hours of approved graduate study during each 3-year membership period. It is the only national medical organization with such a requirement.

The bylaws of the new board call for a termination of the "practice-eligible" category in ten years. After that period, only graduates of approved family practice residencies will be eligible for certification. There is no provision for "grandfathers" — certification can be achieved only by passing the examination. And, periodic recertifications, also by examination, will be required. No other specialty board has a recertification provision.

The examination was prepared by the National Board of Medical Examiners, which designs most similar examinations for medical specialty boards, state licensing boards, and others.

A 50-50 emulsion of mineral oil and milk of magnesia was found to be an almost ideal laxative for the elderly. It was non-habituating, relieved symptoms, and was not complicated by oil leakage.

Treatment Of Constipation In The Aged

Effectiveness Of Mineral Oil And Milk Of Magnesia Emulsion

Michael G. Mulinos, M.D./Westfield*
Ann J. Maloney, M.D./New York

Most people in their advanced years become constipated, increasingly and chronically. It is often a favorite topic of conversation in any group of older people. The choice of a laxative for the aged must take into consideration the desired physiologic action as well as the patient's deeply rooted attitudes toward the importance of this body function. One obvious example is the idea that a daily bowel movement is a *must,* coupled with the growing (and sometimes justifiable) fear that the symptoms may be due to cancer.

Patients admitted to the study were free of organic disease of the bowel and were otherwise normal. Prior to formalization of the project the 50 subjects had been receiving a variety of laxatives and occasional enemas for the relief of constipation and the treatment of abdominal symptoms and distress referable to the bowels. The study was devised to include the oral administration of a simple liquid preparation, an emulsion of equal parts of mineral oil and milk of magnesia, for five months. This period was deemed adequate for the stabilization of the size and frequency of the dose, the adequacy of bowel response, and the incidence and severity of side effects.

During the first month, each subject was given two tablespoonfuls of the emulsion daily, the dose being increased or decreased according to the results. These were recorded as the number of movements per day from none to two, and whether an enema was used. The consistency of the stool was recorded as watery, soft, or hard. Account was kept of all side effects, including complaints on the occurrence of "gas," cramps, abdominal fullness, nausea, urgency, or incontinence, and whether oil leakage occurred between bowel movements. Also, daily results were recorded and interpreted on a subjective basis as good, fair, or poor.

The data were tabulated with the aid of a computer, then analyzed and interpreted by a physician who had not seen the patients and judged the results solely on the basis of the recorded data. There were 44 women and 6 men in the study whose ages averaged 82. Of the 50 subjects, 3 were bedridden, 17 chair-bound, and 30 were ambulatory.

The majority of the subjects reported "good" results most often, as distinguished from "fair" and "poor." A "good" result usually signified patient satisfaction, including a bowel movement with minimal side effects, and minimal bowel consciousness in the interim. Using the frequency of a "good" subjective report during the first month as a base, our subjects fell into two categories. Group A consisted of 36 subjects who had a "good" first month score for less than 20 days out of a maximum of 30.

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These were considered to be constipated and in need of aid in attaining a desirable frequency of regulated bowel movements. The remaining 14 subjects who reported "good" results for 20 days or more during the first month (Group B) were assumed to be less severely constipated because there was less room for improvement from the treatment.

For all 36 cases in Group A (which included all degrees of physical activity), the "good" score increased from an average of 7 days during the first month to 26 during the fifth month of treatment. Since all 50 subjects had been admitted to the study because they were considered to be suffering from chronic constipation, the categorical division at the score of 20 days of "good" results during the first month actually separates the slightly from the more severely constipated.

The validity of this assumption is borne out by the dosage data. Whereas Group B with initial "good" results for 20 days or more was started on two tablespoonfuls of the emulsion daily, only two patients needed an increase to three tablespoonfuls daily (14 per cent). In contrast, Group A with initial "good" results for fewer than 20 days required a dose increase from two, to three and four tablespoonfuls in 14 subjects (39 per cent). The first month score of the 14 subjects in Group B was attained with an average of 21 days, while the more slow responders in Group A required an average of 28 days of medication.

By the fifth month the 14 subjects in Group B were receiving smaller daily doses (one or two tablespoonsfuls) compared to Group A. However, the average number of days during the fifth month that each group received the emulsion was approximately the same and was about half that of the first month.

The gradual reduction in the size of the daily dose and in the number of doses required to achieve "good" results over the five-month period indicates that it was possible to establish a dose-frequency rate for laxation with the laxative over prolonged periods. Contrary to general opinion concerning the chronic use of laxatives "as needed," there was no evidence of habituation. In fact, as time elapsed, both the size of the daily dose and the frequency of administration were reduced as reflected by the excellent results.

Side Effects

We noted five symptoms associated with constipation and the use of laxatives: gas, cramps, fullness, nausea, and vomiting. Their active rate of occurrence declined in all cases from the first through the fifth month. The greatest relief obtained was in the sense of abdominal fullness. This occurred in only eight subjects during the fifth month compared to 28 during the first month. The incidence of nausea dropped from 61 to 14 per cent of the patients in the fifth month. The daily incidence for any month was low, with 4.4 for the first month and 1.4 for the fifth. The complaint of gas (borborygmus and flatus) was reduced only slightly. It was present in from 56 to 90 per cent of the subjects. During any month, the incidence averaged less than 7 days.

Oil leakage is a complication peculiar to this medication. It failed to occur, at any time, in only five of the 50 subjects. The number of patients in Group A who complained of oil leakage increased from 4 (11 per cent) during the first month to 12 (33 per cent) during the fifth month. However, in the 14 subjects in Group B the incidence of oil leakage fell from 10 (or 71 per cent) to 2 (14 per cent) between the first and fifth months, consistent with the smaller daily dose of the emulsion.

Comment

Fantus,[1] as far back as 1920, gave a summary on the cathartic habit that has not been improved upon. It was his opinion that the most common cause of constipation in the U.S.A. was the habit of resorting to drugs to induce a daily bowel movement. Earlier, Adams[2] had urged that we prohibit the giving of cathartics to children. These admonitions were supported by Woodmancy,[3] who traced the laxative habits of the adult to emotional factors acquired during childhood.

For the elderly, straining at stool poses a dangerous burden on the cardiovascular system by way of the Valsalva maneuver.[4,5] Hemorrhoids, anal fissures, and rectal prolapse may sometimes be traced to chronic constipation. Femoral, inguinal, or ventral hernias occur more commonly in the elderly and may also be associated with constipation and straining at stool.

There is no wearing out of the propulsive power of the gastrointestinal tract with age.[7] However, as one ages, there is a fall in the basal metabolic rate, estimated at about 5 per cent per decade after age 20, resulting in a reduced intake of food. There is progressive weakening of the abdominal and respiratory muscles due to sedentary habits. Usually there is a poor selection of foods, dictated by jaded tastes, anorexia and achlorhydria,[8] dental disorders, and other factors which result in low bulk diets, dehydration, and occasionally nutritional deficiencies. Important, too, are the psychogenic factors, especially the depressive states.[4] Dependency and feelings of rejection contribute to the overall difficulty of dealing with these patients.

Constipation is one of the most frequent symptoms in patients over 60 years of age.[9] It has been defined[6] as a chronic condition in which there is accumulaton of fecal matter in the lower colon, with inspissation, fermentation, and putrefaction, leading to local and generalized symptoms of mechanical and toxic origin. Mulinos[6] stressed that the number or quantity of the movements is of only incidental concern. The data obtained on the 50 subjects in this study certainly bear out this concept. In fourteen of the subjects, bowel movements during the month were in excess of 20; yet symptoms referable to the abdomen and associated with constipation dictated their inclusion in the study.

Zeman[10] has estimated that the geriatric population by 1975 will reach 21 million. Constipation is a relatively frequent complaint in the aged,[4] and its seriousness should not be underestimated. Hottnick[11] decries the free use of laxatives as well as the abuse of tranquilizers, opiates, and antispasmodics. All of these inhibit colonic motility.

Many of the factors leading to an exaggeration of constipation in the elderly were not present in our 50 subjects. Thus, we had excluded any one with organic disease as the cause of the symptoms associated with the bowels. Special attention was given to the nutritional value of the diet with the use of sufficient bulk, and the administration of laxative foods such as prunes or bran. Every precaution was taken to minimize dehydration, especially in the bedridden subjects, and laxatives had been used sparingly. Exercise was encouraged among the ambulatory patients, and psychiatric advice and treatment were available. Gastric acid content was not determined, but it was assumed that about 35 per cent of the subjects were deficient in this respect.[8]

We chose a commercially available† emulsion of mineral oil and milk of magnesia for study because we felt that it would be effective and relatively free from the side effects of the irritant laxatives. The amount of mineral oil was not excessive and therefore the dangers of lipoid pneumonitis from aspiration during swallowing,[12] loss of oil-soluble vitamins, or absorption of the oil from the gut would be less likely from such an emulsion than from the larger doses needed when mineral oil is used alone. We do not know to what degree, if any, mineral oil is absorbed after chronic ingestion, but there is little evidence that any harm results from its use as a laxative,[13] although excessive use should be avoided.

Summary

The laxative effects of a half-and-half mixture of milk of magnesia and mineral oil, both of USP purity, were assayed on 50 elderly institutional subjects, 44 of them women. Their average age was 82. Thirty were ambulatory, 17 wheelchaired, and 3 bedridden.

The study extended over five months. The

† We used the brand commercially identified as Haley's M-O.

initial dose was two tablespoonfuls daily given as a single potion. The frequency and quantity of subsequent doses were dependent upon the day-to-day results.

Our Group A included 36 patients who reported "good" results for less than 20 days during the month; Group B consisted of 14 who had a score of "good" results of 20 or over. There was an increase in the number of "good" results in Group A from an average score of 7 for the first month to 26 during the fifth month of treatment. Group B changed only from 24 to 25.

In Group A (the more constipated cases) the dose of the emulsion was increased during the first and second months, and decreased thereafter. At the same time, the frequency of administration fell steadily from 28 doses during the first month to 13 during the fifth month.

In Group B both the size of the dose and the frequency of administration diminished steadily during the observation period, showing a distinct lack of habituation to the laxative.

The incidence of gas, cramps, fullness, nausea, and urgency was found to decrease with time. The complaint of "gas," which was present initially in most of the subjects, was reduced the least, although the monthly incidence was low. Relief was obtained from all of the other symptoms, especially those associated with a sense of abdominal fullness.

Our conclusion was that the emulsion of mineral oil and milk of magnesia is a useful laxative for the elderly. It did not prove to be habituating over the relatively long period of 5 months of use. It relieved a majority of the symptoms associated with constipation, due to its satisfactory laxative effects.

Oil leakage occurred in less than one third of the subjects, but was not sufficiently large to lead to discontinuance of medication.

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549 Birch Avenue

204th ANNUAL MEETING

May 16-19, 1970 Atlantic City

Cardiac arrest following severe blood loss need no longer be considered hopeless. External cardiac massage may be, literally, a life-saver.

Cardiac Massage As A Life-Saver After Severe Hemorrhage*

Henry A. Connolly, Jr., M.D./Summit

Two cases of cardiac arrest, subsequent to sudden and severe hemorrhage, were successfully treated by external cardiac massage. The literature contains many references to the value of internal and external technics of cardiac massage. Because of the important role of external cardiac massage this brief account is offered in the hope that others faced with a similar catastrophe will be encouraged to institute immediate external massage.

Case I

A 73 year old male was brought to the operating room for emergency laparotomy with the diagnosis of "acute abdomen." He seemed to be in shock with a blood pressure of 90/70 and a pulse of 108. Respirations were 28 and shallow. The abdomen was distended, rigid, and without peristalsis. He was dehydrated. Hemoglobin was 15 Grams; hematocrit 52 per cent. He was given an intravenous 1000 cc (electrolyte #158) prior to coming to the operating room. Before anesthesia and surgery was begun a second intravenous was started. When the abdomen was opened there was a sudden gush of blood. The massive loss of blood resulted in a hypotension and precipitated "cardiac arrest." This was immediately called to the attention of the surgeon. Cessation of the heart beat was simultaneously noted by the anesthesiologist and the surgeon. The surgeon was requested to institute external cardiac massage while the anesthesiologist concentrated on the replacement of the blood volume. In a matter of 15 minutes after adequate blood volume (1000 cc whole blood) replacement (and clamping the hemorrhaging blood vessel), the pulse and blood pressure returned spontaneously. Vasoxyl® 10 mgms, Solu Cortef® 100 mgms along with 500 cc Dextran® were also given. Estimated blood loss was 1,300 cc. There was no loss of respiration at any time. Higher concentrations of oxygen were introduced into the anesthestic circuit. The assistant surgeon was able to keep a count of the pulsations by direct palpation of the abdominal aorta. The immediate post operative hemoglobin was 15 Grams, hematocrit 47 per cent. Three days later, hemoglobin was 13.5 Grams, hematocrit 38 per cent. The patient made an uneventful and full recovery.

Case II

A woman in her late thirties, gravida 6, had a normal spontaneous delivery followed by severe uterine hemorrhage. There was no evident laceration but the uterus would not respond to Pitocin® or like drugs. She lost a great deal of blood from the atonic uterus. At this point an anesthesiologist was summoned, and he noticed that the patient had no palpable pulse but that her respirations were still spontaneous and regular. Immediate external heart massage was instituted by the anesthesiologist. Another physician monitored the radial pulse of the patient's right arm and indicated when the massage was adequate or inadequate. While replacement of the blood loss was being attempted, it was decided to do a laparotomy. External cardiac massage was continued throughout the surgical procedure. Motion caused by the external massage did present a problem to the surgeon but this was overcome by pausing for an instant while a vessel was clamped, cut, or ligated. It was noted that the only observable pulsation in the abdominal aorta resulted from the external massage. The uterine vessels supplying the atonic uterus were clamped, ligated, and cut, and a total hysterectomy was done. The obvious hypovolemia was corrected with 3,000 cc of whole blood. Also administered were scopolamine grains 1/150, Solu Cortef® 100 mgms, and 10 per cent calcium gluconate. One thousand cc 5 per cent glucose in water, with 20 mgms neosynephrine, was titrated until the whole blood replacement was completed. Alkaline intravenous solutions were administered *via* bilateral leg cuts downs. Blood pressure and pulse were monitored by radial pulsation. Hemoglobin, 12 Grams prior to delivery, was 9.4 Grams after surgery. By the time of abdominal closure, the blood pressure had returned to 100/72. Upon admission to the intensive care unit the patient responded to her name.

There was no evidence then of any cerebral or myocardial damage even though the external cardiac massage had lasted one hour and twenty-five minutes before the patient's pulse and blood pressure returned on its own. During recovery and upon reacting, she noticed a numbness in the finger tips of her right hand and with her eyes shut was unable to identify objects placed in her hand. A neurologic consultant felt that

* This work is from the Overlook Hospital in Summit, New Jersey, where Dr. Connolly is chief of the Department of Anesthesia.

these disturbances were the results of cerebral damage most probably due to some degree of anoxia. The only anesthesia that this patient required during the entire operative procedure was 4 L flow nitrous oxide and 2 L flow oxygen. At all other times she received oxygen only. Within three months of the episode, she had made a complete and full recovery.

What caused the cardiac arrest in these two cases? It seems clear that the culprit was "hypovolemia!" After all, the heart is a pump. Sudden, massive loss of circulatory volume interferes with the normal pumping action of the heart and cardiac arrest may ensue. When the external closed chest massage technic is employed, the negative pressure within the thorax is maintained. This increases the circulatory volume to the heart. At the same time, the heart is helped to pump out blood to the vital body organs. As a result the myocardium and brain are supplied with the necessary oxygen—until the hypovolemia is corrected and the heart can once again function on its own.

Previously, when cardiac arrest occurred following severe hemorrhage, the most common attitude was hopelessness. There is now no need for pessimism. The two cases presented have illustrated the value of the external cardiac massage. Even in the supposedly hopeless situations of severe hemorrhage a patient can be successfully revived.

Only closed chest external cardiac massage was done on these two patients. If the external technic had *not* been adequate, without hesitation an internal open chest cardiac massage would have been tried.

Technics

The technic of external closed chest cardiac massage by Kouwenhoven at John Hopkins was followed.[1] A slight variation in the technic was perhaps the stance assumed by the person performing the external massage. Rather than standing at the patient's side, it was found to be less fatiguing and out of the way of the surgeon, when the performer stood at the patient's head, with the patient in a Trendelenburg position.

In addition to blood and cut downs to maintain patient veins, the patients received other supportive therapy such as vasopressors, oxygen with artificial respiration, cortisone, intravenous fluids, calcium gluconate, and plasma expanders. Immediate post-operative (as well as follow up) electrocardiogram reports were normal.

Summary

Two cases of cardiac arrest resulting from the hypovolemia of severe hemorrhage have been presented. The employment of external, closed chest cardiac massage was emphasized as a valuable method for the successful revival of patients in this supposedly hopeless situation.

Reference

1. Kouwenhoven, W. B.; Jude, J. R.; and Knickerbocker, G. G.: "Closed Chest Cardiac Massage," *J.A.M.A.*, 173:1064 (July 1960)

159 Mountain Avenue

Qualifications For Nuclear Medicine Technologists

At its July 1969 session, the AMA House of Delegates adopted essential qualifications for nuclear medicine technologists which include a twelve-month uninterrupted program covering approximately 300 didactic hours. The subjects to be covered should include anatomy, physiology, pathology, radiation and nuclear physics, therapeutic radionuclides, and radiochemistry. Although the survery teams may require several months before accrediting the schools, applications for accreditation are now being accepted by the AMA Department of Allied Medical Professions and Services.

Dermatology isn't just eczema. Think of the collagen diseases, too.

Clinical Cutaneous Lesions In The Collagen Diseases

Roger H. Brodkin, M.D./Irvington

Argument exists as to the definition of a collagen disease but for our purposes lupus erythematosus, scleroderma, dermatomyositis and polyarteritis nodosa will be here reviewed.

Lupus Erythematosus

Lupus erythematosus may arbitrarily be divided into a benign cutaneous disorder and a more grave systemic form. In the primarily cutaneous form of this disease, onset may be at any age, but is most common in the 30 to 40 year age group. Females are more frequently affected than males. Early summer is the peak season of onset. The patient may be nonsymptomatic or the eruption may be accompanied by fatiguability, malaise, and vague muscle and joint pain.

The dermatologic lesions may be acute, widespread, and explosive in onset or chronic indolent, and localized. They are nonsymptomatic although tenderness may be a feature. Sites of predilection are the face and particularly the bridge of the nose and malar areas. The forehead, scalp, and ears are also commonly involved. Less frequently the extremities, particularly the dorsal hands and interphalangeal areas are affected. The palms, torso, chest, lips, and buccal mucosa are also sites of involvement. Often the acute eruption conforms to photosensitivity pattern sparing the orbits and shaded areas around the mouth and neck and the covered areas of the body. The distribution may be unilateral or bilateral and may or may not be symmetrical.

The primary lesion is an erythematous macule or papule often with distinct telangiectasia. By extension and coalescence of these lesions, plaques of varying size and shape may be formed. The primary lesions are surmounted by an adherent scale which may vary from a thin translucent flake to a thick verrucous excrescence. Typically the follicular orifices beneath the scale are dilated and filled with keratinous projections of the scale so that when the scale is lifted these extensions provide a "carpet tack" appearance on the undersurface. Pigmentary alterations accompany or follow these lesions especially when they are chronic. The central portion of the plaque is usually depigmented while the border is hyperpigmented. If the inflammatory process is sufficiently prolonged and severe, scarring of varying degree may result with atrophy of the skin and loss of adnexae.

Unusual variants of these lesions are seen and include lupus erythematosus profundus which usually occurs on the face. The primary lesions are subcutaneous nodules of varying size which are firm, rubbery, sharply defined, and persistant. The overlying skin may appear normal or like typical chronic lupus. Bullous lesions are uncommon. They resemble erythema multiforme and may be acute or chronic and recurrent. Chilblain-like lesions involving the fingers, toes, nose, and ears and atrophy with hyperextension of the terminal phalanges as well as dystrophy of the nails have also been described.

Non specific cutaneous lesions include a

* Read before the Sections on Dermatology and Medicine, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1969.

variety of vascular reactions such as macular erythemas, urticaria, purpura, and livedo. Associated lesions include bilateral parotid enlargement, Raynaud's phenomenon, and porphyria.

In systemic lupus erythematosus these lesions as well as the characteristic telangietatic erythema of the face are seen. Reticulate telangiectatic erythema of the palms, finger tips, and dorsal interphalangal areas of the fingers, necrotic ulcerations of the digits and legs, hemorrhagic bullae, cutaneous sclerosis, alopecia, rheumatoid-like nodules, and splinter hemorrhages of the nail beds are also seen in systemic lupus erythematosus.

Scleroderma

Scleroderma includes morphea, a cutaneous type which involves only the skin and subjacent structures, and acrosclerosis and progressive systemic sclerosis which are associated with disease of internal organs. Morphea is more often found in females and affects all ages being most common in the 20 to 40 year age group. It is rare in Negroes. The lesions usually appear spontaneously but have been reported following trauma, infection, pregnancy or the menopause. In morphea, three types of eruptions are seen: guttate, plaque type and linear. The guttate and plaque type eruptions are similar except that guttate lesions are smaller and more numerous. The onset is acute or insidious. Sites of involvement are the limbs, face, genitalia, or torso with a tendency to spare the crural areas. They vary in size from one centimeter in the guttate type to two to fifteen centimeters in the plaque type. They are nonsymptomatic and are frequently multiple, often bilateral but usually not symmetrical. Early lesions may be erythematous, edematous, hyperpigmented, faintly purplish, or mauve colored. Later they become pale, waxen, and ivory in the center with a lilac hue at the border. The surface is smooth and shiny, hair is absent and sweating is diminished. The surface rarely presents nodules, vesicles, patchy hyperkeratosis, bullae, purpura, and telangiectasia. The plaques feel fixed to the deeper tissues and may be hypesthetic. Deeper atrophy of underlying structures may occur accompanied by obscure pains in the underlying area.

Linear lesions also present the same essential features as the plaque type though the lilac border is thinner. They are usually single and unilateral, but bilateral lesions occasionally occur. The extremities, particularly the legs, are more frequently involved than the trunk. Linear lesions may be accompanied by involvement of underlying muscle and bone resulting in disturbances in growth. Frontoparietal lesions may occur with or without facial hemiatrophy which are called *coup de sabre*. Such lesions when they extend into the scalp produce a linear atrophic area of alopecia. The mouth and gums may be involved altering the direction and spacing of the teeth but sparing the periodontal membrane. The tongue may also be involved and exhibit atrophy. Atrophy of the facial bones may involve the orbit producing exophthalmos and disturbed oculomotor function and also affect the iris and fundus.

Associated lesions include localized arthralgia, Raynauds phenomenon, migraine, colicky abdominal pain, spina bifida, sacralization of lumbar vertebrae, kyphosis, scoliosis, sciatic neuralgia, cervical ribs, torticollis and atrophic clavicle. Associated cutaneous abnormalities include verrucous, vascular or pigmented nevi, cafe au lait spots, alopecia areata, vitiligo, generalized ichthyosis, hyperpigmentation, dystrophy of the nails and hirsutism. These types of lesions tend to improve gradually after a long time but residual hyperpigmentation, calcinosis, contractures, and atrophy may persist.

Acrosclerosis or progressive systemic sclerosis has about the same sex and age prevalence. Early features include Raynaud's phenomenon, swelling of the hands and joints, ulcerations, whitlows or gangrene of digits. Leg ulcers and calcinosis have also been described as early features. Early systemic symptoms include weight loss, dyspnea, gastroesophageal reflex, dysphagia, constipation, diarrhea and abdominal pain. The hands and face are in-

volved earliest with changes extending proximally to the forearms. The feet are less severely and less frequently involved. The facial apearance is characteristic. The forehead is smooth and shiny. The lines of facial expression are smoothed. The nose is pinched and beaked and the mouth is constricted, with slight parting of the lips and radial furrowing of the lips. The hands, too, gradually assume a characteristic appearance beginning with swelling and later atrophy which starts at the finger tips and may even result in absorption of terminal phalanges. The fingers become tapered and fusiform. The skin is thin, shiny and feels rough, hard, and hidebound. Erythema and telangiectasia are seen on the palms, nose, and malar areas. Calcium deposits appear as painful ulcerations of the knuckles from which a chalky material is extruded. The sclerotic skin may show pigmentary alterations of varying degree and dilated nailfold capillaries are sometimes apparent. Less common findings include a heliotrope color of the eyelids and nodules which resemble erythema nodosum. Calcification is observed around the iliac crests, knees, feet and elbows, less commonly than the hands.

Dermatomyositis

Dermatomyositis is a rare disease involving skin, muscle, and blood vessels. It is characterized on the skin by erythema, edema, and calcinosis. Calcinosis is more severe in childhood, the prognosis is better for living and it is not associated with an internal malignant tumor. Association with an internal malignancy is common in adult life where calcinosis is often less marked and the process is more frequently fatal. In childhood the peak incidence is before age of ten. Among adults, it is usually between the ages of 40 and 60. Females are affected twice as frequently as males.

The clinical features are variable depending upon the severity of involvement of skin and muscle. Typically one finds muscle pain, tenderness, and weakness accompanied by fever, malaise, and joint swelling. Raynauds phenomenon occurs in 10 per cent of adults but is rare in children. The typical picture includes a purplish-red heliotrope erythema and edema of the eyelids, peri-orbital areas and cheeks. Erythema and edema may also involve the hands, arms and torso, particularly the upper back. Scaling, bluish-red plaques of erythema commonly occur around the base of the fingernails and dorsal fingers over the knuckles. Nailfold capillaries may be dilated, irregular, and tortuous. As the acute changes subside, a reticulate telangiectatic erythema with areas of atrophy, scarring hyperpigmentation and hypopigmentation may be seen resembling chronic radiodermatitis.

Associated with these typical changes, a wide variety of lesions have been reported including dermographism, bullae, urticaria, photosensitivity, erythema nodosum, erythema multiforme, follicular hyperkeratosis, hypertrichosis, hyperhidrosis, and pitting of the fingernails. Rarely erythroderma, diffuse alopecia, livedo reticularis, and ulceration of skin occurs. Muscle weakness typically involves proximal muscle groups of the limbs but muscles of speech, swallowing, and eye movements may also be affected. Calcification of muscles occurs in more than half the cases in childhood and 15 per cent of adults and involves mainly the shoulder and pelvic girdles and the elbows and hands. Calcification is also common in subcutaneous tissues resulting in ulceration and cellulitis. It is said to be a good sign for survival but frequently results in crippling.

Associated diseases include not only occult carcinoma but also lymphoma, Hashimoto's disease, thymoma, hemoalytic anemia, and systemic amyloidosis.

Polyarteritis Nodosa

A discussion of polyarteritis nodosa plunges one immediately into a maelstrom of "angiitides and granulomatoses" of such great diversity and "auto immune diseases" of such variety that some mention must be made of classification. In a chart developed by Alarcon-Segovia and Brown, the position of polyarteritis nodosa as described by Kussmaul and

Meyer is defined as a pure vasculitis and the overlapping of some of the variants and related diseases is illustrated.

Polyarteritis nodosa occurs four times more frequently in males than females and may appear at any age. It generally follows an intermittent acute or chronic course ending fatally within several months or years. The presenting symptoms are protean with fever, weight loss, myalgia, arthralgia, pulmonary or abdominal complaints.

Considering the dermatologic findings, the disease may follow a more benign course with predominantly cutaneous findings, or a more lethal course with signs and symptoms predominantly resulting from its affects on internal organs.

In the more benign cutaneous forms, the problems of classification become important and such names as allergic granulomatous arteritis of Zeek, giant cell arteritis, Wegeners granulomatosis, nodular dermal allergide of Gougerot, Henoch-Schcenlein purpura and others might be included as variants. In the forms with predominantly systemic involvement, 25 per cent are said to show cutaneous lesions. Erythematous macules, papules, and nodules as well as vesicles, pustules, and bullae are seen as primary lesions. The picture may resemble a toxic erythema, urticaria, erythema multiforme, erthema nodosum, or purpura depending upon how severely the structure and function of the involved vessel has been affected. Secondary lesions include the stigmata of resolving inflammation such as hyperpigmentation, scaling and crusting. If total occlusion of a vessel occurs, necrosis results, and one sees gangrene of the skin. This is represented by crusting, erosions, ulcerations, and scarring. If the process is deeper, involving subcutaneous arteries, nodules may be seen or palpated which may be nonsymptomatic but usually are painful or tender. The overlying skin may vary from normal to red or purple or may even be necrotic.

40 Union Street

Scholarship for OT Students

The Anne Ash Moss Scholarship Fund has been funded through contributions from friends and personal funds of Gertrude O. Ash, M.D. in memory of Dr. Ash's daughter, Anne Ash Moss.

Anne Ash Moss was a graduate of Weequahic High School, New Jersey, and held a B.S. Degree in Occupational Therapy from San Jose State College, California. She had looked forward to a fruitful career in this profession of much needed service to humanity. She passed away at age 22 on December 1, 1968.

The intent of this scholarship award is to make possible a career in Occupational Therapy for an eligible female candidate, so that the same high standards envisioned by Anne Ash Moss may be carried forward. The Fund offers an award of $1500 per year for training in Occupational Therapy, to be granted annually for the period of training on the basis of maintaining a satisfactory record. For further information and for an application form write to Gertrude O. Ash, M.D., 561 South Orange Ave., South Orange, N.J. 07079.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 21, 1969

A regular meeting of the Board of Trustees was held on July 20, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Seminar on Gonorrhea . . . Concurred in the action of the President authorizing MSNJ cosponsorship, with the State Department of Health, the National Communicable Disease Center, and the New Jersey Public Health Officers Association, of a seminar on gonorrhea to be held on November 5, 1969 in New Brunswick.

Regional Medical Program . . . Reappointed Dr. Joseph R. Jehl as MSNJ representative on the Regional Advisory Group of the New Jersey Regional Medical Program.

Symposium on Human Sexual Inadequacy . . . Agreed to be listed as a cosponsor of the Carrier Clinic's November 5 symposium on "The Rapid Treatment of Human Sexual Inadequacy."

New Jersey Orthoptic Commission . . . Approved the request of the New Jersey Academy of Ophthalmology and Otolaryngology to submit the following nominees to the Governor for his consideration in appointing one to the New Jersey Orthoptic Commission:

Samuel Diskan, M.D., Atlantic City
Anthony M. Sellitto, M.D., South Orange
John Sullivan, M.D., Arlington

White House Conference on Food, Nutrition, and Health . . . Directed that the following names of physicians willing to participate in the White House Conference on Food, Nutrition, and Health, November 30 through December 4, be submitted to the AMA:

Harvey P. Einhorn, M.D., South Orange
S. William Kalb, M.D., Newark

"Dr. Nicholas A. Bertha Day" . . . Congratulated Dr. Bertha on the recent proclamation, by the Mayor of Wharton, New Jersey, of a day in his honor which officially recognized Dr. Bertha's years of service to that area.

JEMPAC Dues—Billing and Collection . . . Directed that the following opinion of our legal counsel, E. Powers Mincher, concerning the inclusion of JEMPAC contributions in billing for membership dues be forwarded to the County Societies, with a statement pointing out that the opinion is *not* a directive, and that the decision for such billing remains the prerogative of each component society. This is dated August 6, 1969.

The determination of whether a County Medical Society may, with impunity, add JEMPAC contributions to its billing for membership dues is dependent upon proper interpretation and application of the Federal Corrupt Practices Act (18 USC 597 et seq.) and Section 501 of the Internal Revenue Code (26 U.S.C. 501).

Section 610 of the Federal Corrupt Practices Act provides:

"*It is unlawful* for any national bank, or any corporation, organized by authority of any law of Congress, to make a contribution or expenditure in connection with any election to any political office, or *for any corporation whatever,* or any labor organization *to make a contribution or expenditure in connection with* any election at which Presidential and Vice Presidential electors or a Senator or Representative in, or a Delegate or Resident Commissioner to Congress are to be voted for, or in connection with any primary election or political convention or caucus held to select candidates for any of the foregoing offices, or for any candidate, political committee, or other person to accept or receive any contribution prohibited by this section . . ." (italics by Mr. Mincher)

In the case of U.S. v Painters Local Union No. 481 (172 F 2nd 854) it was held that the Union's expenditure of $111.14 for the cost of political advertisement in a daily newspaper of general circulation and $32.50 to pay the cost of a political radio broadcast over a commercial radio station, advocating rejection of a candidate for Republican nomination for President and his defeat in the Presidential election if nominated and rejection of six incumbent Congressmen as candidates for re-election and their defeat in Congressional elections if nominated, did not violate Section 610!

In a so-called landmark case of 1948, U.S. v Congress of Industrial Organizations (335 U.S. 106) the Supreme Court held that publication of a labor union periodical distributed to members and other regular subscribers urging the election of a certain candidate for Congress was not violative of Section 610.

In reaching this conclusion the Court said the term "expenditure" was *not* a word of art, had no definitely defined meaning and the applicability of that term to prohibition of particular acts must be determined from circumstances surrounding its employment. The Court further pointed out that if the language of Section 610 was construed strictly, its prohibition against contributions and expenditures in connection with a national election would conflict with the right of freedom of speech and of the press guaranteed under the first amendment to the Constitution. The Supreme Court and all lesser federal courts consistently thereafter interpreted and applied the provisions of Section 610 in such fashion as to avoid that conflict.[1]

In addition to proving a contribution or expenditure was made, it must be established that the same was made "in connection with" an election to a federal office before Section 610 is violated. All section 610 cases reviewed involved "contributions or expenditures" closely related to such elections. Additionally, in all such cases, the activity of the person charged with violation of the law directly related to a campaign for a federal office or offices.

It is my understanding County Societies generally bill their members late in November or early December, in any event subsequent to the general elections in November. Such fact makes it most unlikely that such a billing, so remote in time, could be construed as having a casual "connection with" an election to federal office.

In view of the issues as considered above, namely, that Section 610 is constitutionally suspect, our courts have concluded inconsequential contributions or expenditures are so remote or indirect as not to be violative of Section 610 and the billing procedure proposed would not be directly related to a campaign for federal office, it does not appear that the proposed billing would be violative of the Federal Corrupt Practices Act.

Before one may properly conclude whether the proposed billing would be a threat to a component society's best interests, as well as those of The Medical Society of New Jersey, consideration must be given to Section 501 of the Internal Revenue Code. I expect the tax exempt status of most of our component societies, like that of the Medical Society of New Jersey, is based upon Section 501 (C) (6) of that Code, which provides as follows:

"Section 501 Exemption from tax on corporations, certain trusts, etc.

(a) Exemption from taxation—An organization described in subsection (c) or (d) or . . . shall be exempt from taxation . . .

(c) List of exempt organizations—The following organizations are referred to in subsection (a)

. . . (6) Business leagues, chambers of commerce, real estate boards, boards of trade, or professional football leagues (whether or not administering a pension fund for football players), not organized for profit and not part of the net earnings of which inures to the benefit of any private shareholder or individual." . . .

It is apparent there are no proscriptions against political contributions or expenditures under the provisions of the above language. However, a component society may have been granted an exemption under the provisions of Section 501 (c) (3) which provides as follows:

(3) Corporations, and any community chest, fund or foundations, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, *no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.* (italics by Mr. Mincher)

The position taken by our federal courts in the Federal Corrupt Practices Act cases, plus the fact that billing activities are but a miniscule part of a component society's activities, warrant a conclusion that subsection (3), quoted above, would not be violated by the proposed billing considered herein. I found no case decision under the Internal Revenue Code concluding what is or what is not a "substantial part" of an organization's activities. I am of the opinion that the proposed billing would not be held to be a violation of Section 501 (c) (3) or (6).

Although I conclude that the proposed billing would not be violative of the law, in the last analysis it is for the component societies to determine what action they shall take. Represented as they all are by competent counsel, I have no qualms concerning the propriety of the action they ultimately may take.

Assuming the election may be to bill as proposed, there are a few more matters worthy of mention. As a practical matter and to provide circumstantial guarantees protecting the legality of its action, the component society should consider the following:

1. Receipt of component and MSNJ dues plus JEMPAC contributions in one check from a physician results in co-mingling of funds. When JEMPAC contributions are forwarded under a County Society check, it could be argued that that Society, not the physician, was making a contribution. This may be avoided by establishing a trust account in an appropriate title indicating funds therein are in trust for distribution to designated beneficiaries—JEMPAC—component society—The Medical Society of New Jersey—etc.

A simpler solution would be to require the physician to write two checks, one to cover his membership assessments to The Medical Society of New Jersey, his component society, and the AMA and the other drawn to JEMPAC for his voluntary contribution.

2. The issue of "contribution or expenditure" could best be avoided by charging a fee sufficient to cover cost of billing and distribution or a fee reflecting a nominal profit on such activities.

3. The bill should be made in such form and manner as to make crystal clear to the physician member that the JEMPAC item is purely voluntary and such contribution as may be made is not deductible for income tax purposes.

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[1] U.S. v Construction & General Laborers Local Union '51 101 F. Supp 869
U.S. v International Union United Auto '57 77 S. Ct. 529
U.S. v Anchorage Central Labor Council '61 193 F. Supp 504
U.S. v Lewis Food Co. '64 236 F. Supp 849

Annual Meeting . . . Approved the report of the September 14 meeting of the Annual Meeting Committee, including the following recommendations:

1. That the Exhibitors' Reception-Buffet in 1970 be retitled, "Members and Exhibitors Reception-Buffet"; and that members and their wives be invited to attend at their own expense.

2. That the cocktail hour for this Reception-Buffet be limited to one hour; thereafter the bar would be open on a "dutchtreat" basis.

3. That in support of the educational efforts to procure more outstanding speakers at the scientific sessions (thus incurring increased travel expenses and honoraria) invitations be extended to pharmaceutical houses, book publishers, instrument and supply houses, and other approved agencies offering services or products to the medical profession to be included in an annual list of "Official Patrons of the Educational Programs of The Medical Society of New Jersey." Place on such a list would be given to contributors of $100 or more.

4. That a letter go to the two New Jersey medical schools, with copies to each class president, inviting students to visit the 1970 annual meeting and offering transportation if a sufficient number is interested in attending.

5. That, following the close of the first session of the House of Delegates, there be an "Open Discussion on Medicare/Medicaid," with a panel composed of representatives of the Department of Institutions and Agencies, Prudential Insurance Company (fiscal intermediary), the Social Security Administration, and perhaps someone from the Federal Government.

Committee on Project Hope and Vietnam . . . Approved a recommendation that a $1,000 fellowship be given to Richard D. Snyder, M.D. of Bergen County who has been cleared for a *Project Hope* tour of duty to Tunisia November 15, 1969 to January 15, 1970.

Air Quality Standards . . . Approved the recommendation of the Committee on Environmental Health that The Medical Society of New Jersey go on record as endorsing the proposed *Air Quality Standards* dealing with the sulphur content in fuel oil (to be known as chapter 13) and urge their prompt incorporation into the New Jersey Air Pollution Control Code.

AMA Clinical Convention . . . Authorized attendance (with expenses paid) at the AMA Clinical Convention in Denver, November 30 through December 3, 1969, of Dr. Louis F. Albright of Spring Lake to serve for Dr. Jerome G. Kaufman (regular delegate who cannot attend), and Dr. Joseph R. Jehl of Clifton as alternate-delegate.

Transfer of Journal Printer . . . Approved a recommendation that, effective with the November 1969 issue, the MSNJ contract for printing *The Journal* be amended only to the extent that *The Journal* will be printed at another subsidiary of Printing Corporation of America, namely, the Hughes Printing Company at East Stroudsburg, Pennsylvania. All other provisions of the contract will remain.

Immigration Aspects of Mutual Education —H.R.445 . . . Directed that MSNJ officially record its support of H.R. 445 which requires a foreign student from an underdeveloped country to return to his homeland at the completion of his education rather than have his status changed so as to enable him to take up permanent residence here; and that this position be transmitted to the proper congressional authorities.

Conference of Presidents . . . Authorized scheduling the fall conference of presidents and presidents-elect of county societies at the Executive Offices on October 19, 1969.

New Jersey College of Medicine . . . Granted permission for a representative of the New Jersey College of Medicine and Dentistry to attend local meetings of county societies—provided the societies so agree—in an effort to explain the studies, functions, and aspiration of the school.

MSNJ Scientific Exhibits

Members of The Medical Society of New Jersey are invited to participate in the Scientific Exhibits at the 204th Annual Meeting, May 17 to 19, 1970.

For information and application form, see pages 635-638 of this issue, or con-
Meeting, May 17 to 19, 1970.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Disease during September:

	1969 September	1968 September
Aseptic Meningitis	59	94
Primary Encephalitis	6	6
Post-Infectious Encephalitis	0	2
Hepatitis, Total	203	136
Infectious	169	119
Serum	34	17
Malaria	16	14
Military	11	10
Civilian	5	4
Meningococcal Meningitis	3	5
Civilian	3	
Mumps	22	27
German Measles	11	2
Measles	11	8
Salmonella	66	60
Shigella	27	8

Influenza Vaccine

Following the widespread epidemic of A2 Hong Kong influenza that occurred last year, very little influenza activity is anticipated in the coming winter months. The New Jersey State Health Department endorses the recommendations of the USPHS *Advisory Committee on Immunization Practices* for the use of vaccine for the 1969-1970 influenza season. Influenza vaccine is recommended only for those groups at high risk, such as the *elderly* and the *chronically ill*. Large immunization programs are otherwise not encouraged. A bivalent vaccine is available containing both Hong Kong A2 antigen (A2/Aichi/2/68) and type B antigen (B/Mass/3/66). The primary vaccination series consists of two doses separated by a 6 to 8 week interval. High risk individuals who regularly receive influenza vaccines (and who had one or more doses of the monovalent Hong Kong antigen vaccine during the 1968-1969 season) require only a single full dose booster of the bivalent vaccine. Immunizations should be completed by early December 1969.

Toxoplasmosis

Recently the New Jersey State Serology Laboratory has received many specimens for indirect fluorescent antibody titers obtained from patients in whom acquired toxoplasmosis has been suspected. A plea for caution in the interpretation of the results is in order. A definitive diagnosis of toxoplasmosis is made either by isolation of the organism from mice after injection of infected material or by recognition on histologic sections of biopsy specimens. A positive antibody titer means that an individual has been infected at some time. A rising titer on serial specimens is compatible with a recently acquired infection. A stable titer indicates that the patient has had an infection in the past. Thus, both acute and convalescent phase sera are necessary for meaningful information about recently acquired infections.

Toxoplasma gondii is an obligate intracellular protozoon that is able to parasitize any cell of its vertebrate hosts except non-nucleated red blood cells. It is widely distributed throughout nature, being found in man, birds, and animals in almost all parts of the world. Congenital infections result from intrauterine transfer of the parasite from mother to fetus. The exact mode of transmission in acquired infections is unknown; there is evidence suggesting that toxoplasma can be transmitted to man by undercooked meat.

Most acquired infections are either inapparent or unrecognized. In a seriologic survey Feldman has demonstrated antibodies in 20 per cent of military recruits from the East Coast, 8 per cent of recruits from the West Coast and 3 per cent from the Mountain States. Furthermore, the prevalence of antibodies in the population increases with advancing age. A wide range of manifestations has been reported in clinically recognized disease. These include maculapapular skin rash, lymphadenopathy (which has been confused with lymphomatous disorders and with infectious mononucleosis), meningitis and encephalitis, uveitis, pneumonitis, myocarditis, and pericarditis. Disseminated infection has been erroneously diagnosed as collagen-vascular disease. The treatment, which is not innocuous, consists of a combined course of sulfanamides and pyrimethamine, a folic acid antagonist.

FDA Drug Ruling Challenged*

The Food and Drug Administration's authority over the drugs physicians prescribe is facing a crucial test.

The immediate issue is antibiotic combinations and whether FDA is justified in ordering them off the market without an administrative hearing.

Before 1962, FDA's powers over clearing drugs for the market were limited to a determination of the safety of the product, whether it posed an imminent hazard to public health that outweighed its benefits. The agency could rule that efficacy labelling claims were unjustified, but if a drug company balked, the government needed to go to court to press its suit.

The 1962 Kefauver drug amendments, allowed FDA to check new drugs before public sale for efficacy as well as safety. The law also apparently stretched FDA's jurisdiction in this area to all drugs channeled through it from 1938 to 1962, a period which saw the development of most of the drugs in the modern armamentarium.

The pharmaceutical industry at that time expressed concern that this added delegation of power could lead FDA to make possible arbitrary decisions on drugs, decide that brand X is somewhat better and safer than brand Y, and therefore brand Y should be eliminated. The industry and the American Medical Association said that in cases where there is a legitimate difference of opinion the decision should be left to the individual judgment of the practicing physician.

FDA Commissioner James Goddard, M.D., realized a few years after enactment of the Kefauver bill that the massive chore of going back over all drugs then in use would be not only impossible for the manpower-short FDA, but that any rulings based solely on an FDA investigation could be challenged on grounds of bias. Impressive and objective scientific authority was needed to back up future FDA decisions. "With those needs in mind, it seemed plain enough that one organization was uniquely equipped to carry out that review—the National Academy of Sciences—National Research Council," Dr. Goddard said.

NAS-NRC is a prestigious, Washington-based organization that in the main carries on research work under contract with the government.

Some 3,000 drugs sold in as many as 18,000 combinations were waiting review. Different makes of the same drug were not studied separately to determine if any differences existed between generic or brand name products.

NAS-NRC signed the $1 million contract with FDA in 1966. The Academy appointed an advisory committee of outstanding physicians and pharmacologists to select the study panels and review their findings.

It was agreed that panel members, but not their chairmen, would remain anonymous. The panels met from time to time in Washington on call from their chairmen. In between, members pored over available scientific reports, including FDA files, and evidence submitted by drug companies. No independent, new research was performed by the Academy. The eminent panel experts were drawn, largely, from the academic community.

A particular trouble spot apparent at the start would be the fixed combination antibiotic field. Scientific articles for some years had criticized use of fixed combinations as irrational therapy, but many physicians had found the products handy and useful. Most drugs represented a considerable financial investment and return for drug companies. Advertisements for them, cleared by the FDA, sprinkle medical journals.

According to the panelists, combinations deprive physicians of their freedom of choice on dosage. "The use of both drugs simultaneously

* Abstracted from the August 4, 1969 issue of *American Medical News*

therefore increases the risk to the patient, and the combination is to be avoided for this reason."

The conflict was swiftly pointed up by the thousands of letters received by FDA from physicians protesting the move against the combinations, compared with a handful praising the actions. An industry spokesman said, that the astronauts on their moon trip carried combination antibiotics that are on the FDA list.

FDA served notice it intended to stop marketing 12 antibiotic combinations, and followed up with a list of 78 more in April. The agency precipitated the immediate legal battle by ordering all sales of Panalba (Upjohn Co.), one of the original 12, halted and all existing stocks withdrawn. Upjohn filed suit in Federal District Court, Kalamazoo, Michigan, and won a temporary restraining order.

There are many legal issues involved in the case, the primary one being FDA's refusal to give the company a hearing on the withdrawal order and a chance to appeal it. The broader issues, which must also figure, will test FDA's over-all authority.

Dr. Ley, like his predecessors, is thus caught between industry and a segment of the medical profession that believes the FDA has overstepped its bounds, and lawmakers who imply he works in cahoots with the drug industry.

Joseph Stetler, President of the Pharmaceutical Manufacturer's Association, has said that, "Some of FDA's decisions are disquieting because they appear to be panic-button type verdicts in response to outside pressure, verdicts offered in lieu of the orderly administrative procedure designed for no purpose other than to prevent such needlessly precipitate action. There can be no doubt that the duty of FDA is to challenge any prescription product for which no adequate evidence of safety and effectiveness is present. But that duty does not permit FDA to elevate anonymous opinion to dogma, or to require the practitioner to subordinate his own judgment to the 'official' word."

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1, Date of Filing: September 16, 1969.

2. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

3. Frequency of issue: Monthly.

4. Location of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the headquarters or general business offices of the publishers (Not printers): 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor, and managing editor: Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey; Editor, Henry A. Davidson, M.D., 315 West State Street, Trenton, New Jersey; Assistant Editor, Mrs. Marjorie Treptow, 315 West State Street, Trenton, New Jersey.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (if there are none, so state): None.

9. For completion by nonprofit organizations authorized to mail at special rates (Section 132,122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	8,298	8,349
B. Paid Circulation		
1. Sales through dealers and carriers, street venders and counter sales	—	—
2. Mail Subscriptions	7,922	7,951
C. Total Paid Circulation	7,922	7,951
D. Free Distribution (including samples) by mail, carrier or other means	338	368
E. Total Distribution (Sum of C and D)	8,260	8,319
F. Office use, left-over, unaccounted, spoiled after printing	38	30
G. Total (sum of E & F should equal net press run shown in A)	8,298	8,349

I certify that the statements made by me above are correct and complete.

Robert H. Lambert
Business Manager
The Medical Society of New Jersey

204th Annual Meeting
The Medical Society of New Jersey
May 16-19, 1970
Haddon Hall, Atlantic City

Program

Friday, May 15, 1970

4:00 p.m. — Board of Trustees
7:00 p.m. — Buffet Dinner

Saturday, May 16, 1970

10:00 a.m. — Registration Opens
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and their families
2:30 p.m. — House of Delegates followed by open discussion on Medicare/Medicaid
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner

Sunday, May 17, 1970

9:00 a.m. — Registration Opens
9:30 a.m. — Scientific Sessions
10:00 a.m. — Exhibits open
10:00 a.m. — Coffee-meeting with Reference Committee Chairmen
10:00 a.m. — Motion Picture Theatre
10:45 a.m. — Reference Committees
1:00 p.m. — Scientific Sessions
2:00 p.m. — Motion Picture Treatre
3:30 p.m. — House of Delegates (election) followed by addresses of outgoing and incoming Presidents (General Session)
6:00 p.m. — Inaugural Reception
8:00 p.m. — Members-Exhibitors Reception-Buffet
8:30 p.m. — Inaugural Dinner

Monday, May 18, 1970

9:00 a.m. — Registration and Exhibits open
10:00 a.m. — Motion Picture Theatre
9:30 a.m. — Scientific Sessions
2:00 p.m. — Motion Picture Theatre
2:00 p.m. — Scientific Sessions
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 19, 1970

9:00 a.m. — Registration and Exhibits open
9:00 a.m. — House of Delegates
10:00 a.m. — Motion Picture Theatre
3:00 p.m. — Exhibits and Registration Close

Wednesday, May 20, 1970

8:30 a.m. — Board of Trustees

The Scientific Exhibits — — 204th Annual Meeting

The following information is pertinent to the scientific exhibit displays at the 204th Annual Meeting of this Society, May 17 to 19, 1970. Those interested in participating may use the application form on page 637. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Sidney Girsh, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey—in instances where a pharmaceutical company has aided in the production of an exhibit either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 15, 1970, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to Sidney Girsh, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, N.J. 08605.

1. *Time:* The exhibits will open officially at 10 a.m., Sunday, May 17, and close at 3 p.m., Tuesday, May 19. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 11:00 a.m., Saturday, May 16, and all exhibits must be in place by 9:00 a.m., Sunday, May 17. Exhibits must remain intact until 3 p.m., Tuesday, May 19, and should be removed from the exhibit hall not later than 12 noon, Wednesday, May 20.

3. *Cost:* The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign *(if requested)*, and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of all exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

204th Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 17-19, 1970

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

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3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN *not* required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to Sidney Girsh, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

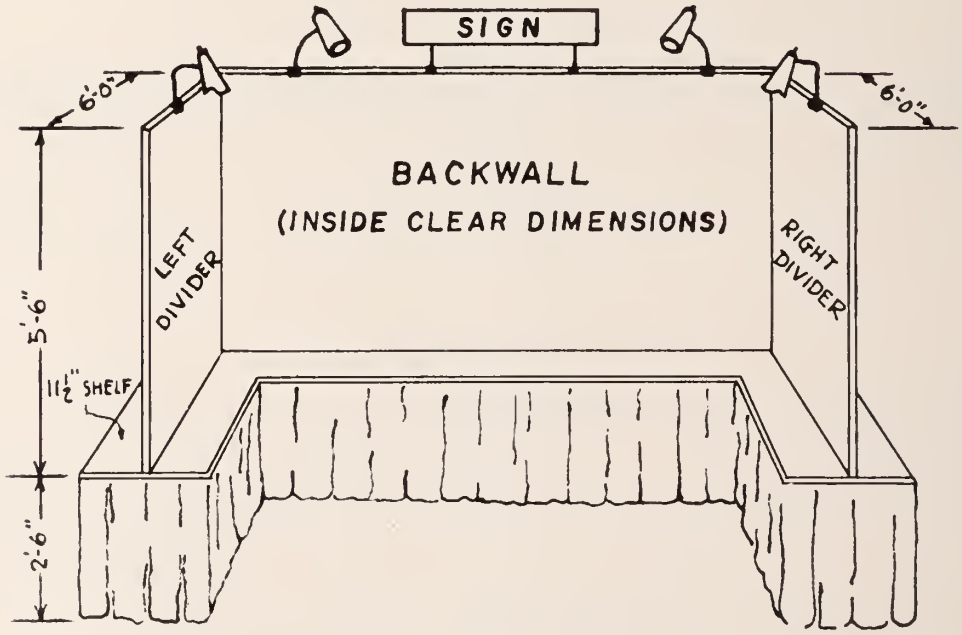
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated within your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

ANNOUNCEMENTS

Cancer Diagnosis and the Computer Van

A novel approach to cancer diagnosis is available, without charge, through the "Computer Van." Sponsored by the New Jersey Academy of Medicine and the American Cancer Society, this is a trailer containing several teletype machines hooked up with a data processing center. Programmed into this are several challenging cancer cases. You call for diagnostic procedures, and you also suggest therapeutic modalities and see the result. Each visit will take 15 to 20 minutes, but it is a swift and painless dose of graduate medical education that will last a long time. The vans will be parked at the hospitals listed below:

Atlantic City—Atlantic City Hospital, May 4-15

Camden—Cooper Hospital, March 23-April 3

Cape May Court House—Tomlin Memorial Hospital April 27-30

Elizabeth—Elizabeth General Hospital, January 5-16

Flemington—Hunterdon Medical Center, December 8-19*

Lakewood—Paul Kimball Hospital, May 21-27

Long Branch—Monmouth Medical Center, February 2-13

Mount Holly—Burlington County Memorial Hospital, March 16-20

Morristown—Morristown Memorial Hospital, November 17-28*

Neptune—Jersey Shore Medical Center, May 28-June 5

New Brunswick—Middlesex General Hospital, January 19-30

Phillipsburg—Warren Hospital, December 1-5*

Princeton—Princeton Hospital, February 16-25

Salem—Salem Memorial Hospital, April 13-17

Somerville—Somerset Hospital, December 22-31*

Trenton—Mercer Hospital, February 26-March 13

Vineland—Newcomb Hospital, April 20-24

Woodbury—Underwood Hospital, April 2-10

* These dates are in 1969. All others are in 1970.

ACP Meeting In New Jersey

Reserve all day, Wednesday, November 19, for the New Jersey Regional Meeting of the American College of Physicians at the Robert Treat Hotel in Newark. A varied scientific menu has been provided, which includes such items as drug abuse, family planning, cardiomyopathy, organ transplantation, and alcoholism. For details, write to Mortimer L. Schwartz, M.D., 51 Sommer Avenue, Maplewood.

Clinical Application Of Basic Sciences

The series on basic sciences and clinical application offered by the Burlington County Memorial Hospital will present the following program for December:

December 4: Parkinsonisum
December 11: Allergy Emergencies
December 18: Crisis Counseling

All meetings are held at 3:30 p.m. in the T. J. Summey Building at the hospital. Credit of 1½ points per session is given by the AAGP. For registration, please contact J. R. Wolgamot, M.D., Director of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Anesthesiology Program

A one-day anesthesiology program is scheduled for Saturday, December 11, 1969, at 630 West 168th Street, New York City. The current practices at Columbia-Presbyterian Medical Center and affiliated hospitals will be described, emphasizing sound principles of clinical management. Course material will include description of anesthetic technics and procedures in such specialized areas as pediatric surgery, obstetrics, and brain surgery. Also reviewed will be cardiopulmonary problems and other complications during and after operation, and development and use of monitoring devices and special apparatus. You will

have ample opportunity for questions and discussion. Luncheon is included in the $50 fee. For application write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168th Street, New York 10032.

Again The Slide Seminar

The New Jersey Society of Pathologists will hold its 19th Annual Slide Seminar on December 11, 1969 at the Nassau Inn in Princeton, beginning at 2 p.m. Moderators will be J. Churg, M.D., Clinical Professor of Pathology at Mount Sinai Medical School, and Sheldon Sommers, M.D., Professor of Pathology at Columbia University. This year's subject will be "Granulomatous Diseases." You are invited to attend.

Special Ophthalmology Workshop

The Twenty-Second Annual Clinical Conference of the Wills Eye Hospital will be held on February 5 to 7, 1970 at the Bellevue-Stratford Hotel, Broad and Walnut Streets, Philadelphia. The program includes symposia on "Congenital Motor Anomalies," on "Ocular and Orbital Trauma" and on "Macular Disorders."

Inquiries should be addressed to Dr. Robert D. Mulberger, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, Pennsylvania 19130.

American Board of Family Practice

The American Board of Family Practice announces an examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 28 to March 1, 1970. Information regarding the examination and eligibility may be obtained by writing to Nicholas J. Pisacano, M.D., American Board of Family Practice, University of Kentucky Medical Center, Lexington, Kentucky 40506.

OBITUARIES

Dr. Harry L. Glass

Harry L. Glass, M.D., one of our state's prominent anesthesiologists died on September 19, 1969. Dr. Glass won his M.D. degree at the Medical School of the University of Virginia in 1934. After four years of general practice, he completed a residency in his chosen specialty and entered the Army. He was on active duty from 1943 until the end of the war in 1946. Dr. Glass was only 59 years old at the time of his death. He had practiced in Plainfield during most of his professional career.

Dr. Wolf W. Lurie

Born in 1906, Wolf William Lurie, M.D., died on August 24, 1969. He was in the class of 1933 at the School of Medicine of the University of St. Andrews in Scotland. Dr. Lurie was a cardiologist and angiologist, and was chief of cardiology at the West Hudson Hospital in Kearny. He was active in the Academy of Medicine of New Jersey, and a founding Fellow of the Phlebology Society of America.

Dr. Harrison B. Wilson

At the grand age of 78, Harrison B. Wilson, M.D., died in his retirement in Florida on September 23, 1969. Dr. Wilson was one of the busiest obstetricians in Bergen County. He stopped counting after he had delivered the 3,000th baby. He was chief of obstetrics for many years at the Hackensack Hospital, and was a Fellow of the American College of Surgeons. He was an emeritus member of our Bergen County Medical Society.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969

November

12 **New Jersey Academy of Ophthalmology and Otolaryngology**
Robert Treat Hotel
Newark
Seminar on Otolaryngology

13 **Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Morristown Memorial Hospital
Symposium: Neuroblastoma in Children

13 **Burlington County Memorial Hospital**
Mount Holly
Hematologic Problems in Pregnancy

14 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Organization of Coronary Care Units

15 **St. Barnabas Medical Center**
Livingston
Clinical Applications of the Neural Sciences

15 to Jan. 28 **Muhlenberg Hospital**
Plainfield
Graduate Course in Medicine
Part I—Cardiology

18 **Academy of Medicine of New Jersey**
Section on Dentistry
Robin Hood Inn, Clifton
The Dentist and Total Health Care in the Hospital

19 **St. Michael's Medical Center**
Newark
Hematology Advances

19 **Academy of Medicine of New Jersey Section on Radiology, and New Jersey Radiological Society**
Academy of Medicine, Bloomfield
Interesting X-rays of the Month

19 **New Jersey Chapter, American Academy of Pediatrics**
Holiday Inn, Kennilworth
Seminar on Pediatric Allergy

19 **New Jersey State Dental Society**
Semiannual Session

20 **Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
Hypnosis in Medicine

20 **Burlington County Memorial Hospital**
Mount Holly
Microsurgery of the Ear

25 **Hunterdon County Medical Society**

December

3 **Academy of Medicine of New Jersey**
St. Barnabas Hospital
Livingston
Symposium: Shock

3 **Academy of Medicine of New Jersey**
St. Elizabeth Hospital
Elizabeth
Organization of Emergency Room Care

3 **Newark Eye and Ear Infirmary**
The Manor, West Orange
Medical Staff Dinner

3 **St. Michael's Medical Center**
Newark
Volume and Concentration of Body Fluids

4 **St. Joseph's Hospital**
Paterson
Program on Stroke

4 **Burlington County Memorial Hospital**
Mount Holly
Parkinsonism: Assessment of New Therapeutic Modalities

8 **Academy of Medicine of New Jersey and American Cancer Society**
Paul Kimball Hospital
Lakewood
Chemotherapy of Cancer

9 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Workshop on Resuscitation

11 **Burlington County Memorial Hospital**
Mount Holly
Common Allergic Emergencies

16 **Academy of Medicine of New Jersey**
Newcomb Hospital
Vineland
Pulmonary Problems

17 **St. Michael's Medical Center**
Newark
Pathogenesis of Fever

18 **Burlington County Memorial Hospital**
Mount Holly
Crisis Counseling

1970
January

7 **Academy of Medicine of New Jersey**
Symposium: Immunology and Radiation Protection

7 **St. Michael's Medical Center**
Newark
Recent advances in Thyroid Problems

8 **Burlington County Memorial Hospital**
Mount Holly
Newer Anesthetic Agents

14 **St. Michael's Medical Center**
Newark
Portal Hypertension Surgery

15 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Medical Management of Gastrointestinal Hemorrhage

21 **St. Michael's Medical Center**
Newark
New Concepts in Rheumatology

22 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Gastrointestinal Hemorrhage

27 **Hunterdon County Medical Society**

29 **Burlington County Memorial Hospital**
Mount Holly
Indications and Technics for Urinary Diversionary Procedures

February

4 **Academy of Medicine of New Jersey**
Symposium on Immunology

4 to Apr. 29 Muhlenberg Hospital
Plainfield
Graduate Course in Medicine
Part II—Respiratory Diseases

4 **St. Michael's Medical Center**
Newark
Uric Acid Metabolism and Gout

5 **St. Joseph's Hospital**
Paterson
Program on Stroke

5 **Burlington County Memorial Hospital**
Mount Holly
Angiographic and Echographic Diagnosis of Genito-Urinary Lesions

11 **St. Michael's Medical Center**
Newark

11 **Academy of Medicine of New Jersey**
Symposium: "Isotopes and Recent Advances in Radiologic Diagnosis"

12 **Burlington County Memorial Hospital**
Mount Holly
Management of Chronic Renal Insufficiency

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Technics

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

11 **St. Michael's Medical Center**
Newark

12 **Academy of Medicine of New Jersey**
Symposium: Pulmonary Embolism

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

24 **Hunterdon County Medical Society**

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

2 **St. Joseph's Hospital**
Paterson
Program on Stroke

8 **Academy of Medicine of New Jersey**
Hoffman-LaRoche
Nutley
Symposium: "Surgical Management of the Mind"

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

27 **Academy of Medicine of New Jersey**
Annual Awards Dinner

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BOOK REVIEWS

Surgery of the Chest, John H. Gibbon, Jr., M.D.; David C. Sabiston, Jr., M.D.; and Frank C. Spencer, M.D. Philadelphia, 1969, Saunders. Pp. 954. Illustrations 621. ($32.50)

This second edition is an expanded version of its classic predecessor which was so well-received six years ago. The list of contributors has been enriched by the addition of several excellent authors, equally recognized authorities in their fields. The section devoted to cardiorespiratory dynamics was found by this reviewer most interesting. There is an excellent discussion on acid-base balance, and ventilation with oxygen and its relationship to oxygen toxicity, which should be most interesting for those handling intensive cardiopulmonary units. Among the new chapters in this edition are those of assisted circulation, greatly expanded surgical treatment of congenital and acquired heart disease, and a chapter on pulmonary embolectomy, as well as on heart transplants and lung transplants.

When this reviewer compared the new knowledge in surgery of the chest accumulated in the short period of six and a half years between the first and the second edition of this publication, he could not help but admire the authors for being able to present to us this excellent review of chest surgery as it is practiced today. I highly recommend it to all who are engaged in the pactice of thoracic surgery as well as to all medical libraries. It is, indeed, a classic book which should be on the bookshelf along such classics as Grant's Anatomy.

ADRIAN M. SABETY, M.D.

Contact Lens Practice. Jack Hartstein, M.D. St. Louis, 1968, Mosby. Pp. 199. With 90 illustrations ($10.75)

Contact lenses are being worn by more and more people for both cosmetic and visual reasons. In recent years, a larger proportion have been prescribed and fitted by medical doctors. This book tries to cover the entire subject of contact lenses, both scleral and corneal, from history, manufacturing, indications, fitting technics, and handling of related complications.

Much of the background material is unnecessary and could have been omitted. The book includes sections on basic corneal anatomy, pathology, physiology, and fundamental biomicroscopic examination technics, as well as advanced fitting methods for keratocomus and bifocal contact lenses. It is hard to know whether to recommend this book for ophthalmologists, optometrists, or opticians fitting lenses independently or under direction of ophthalmologists.

Throughout the entire book a novel question and answer format is employed to organize the material. In some chapters this is very successful in holding the reader's attention, but in others, the form is tortured and constricting.

The sections most helpful for contact lens fitting are those on signs and symptoms in detecting need for lens adjustment and on correcting unsatisfactory fit.

ARTHUR S. KERN, M.D.

Drugs in Current Use and New Drugs. Edited by Walter Modell, M.D. New York, 1969, Springer Publishing Company. Pp. 201 ($3.25)

Sometimes the practitioner must feel that he is in a jungle of drugs and pharmaceuticals, and that there is no way to hack through this jungle. One has come to expect the tranquilizer of the month, or the steroid of the month and so on. There are, of course, several compendia that offer to come to his rescue. Marion Howard's Modern Drug Encyclopedia, for instance, or the ever popular Medical Economics publication, *Physicians Desk Reference*. These are useful, hard-backed tomes. The text under review is a short, modestly-priced, pocket-sized paper back. It covers most of the medications now in current use, arranged by generic name (with cross references to the commoner trade names) with listing by the primary drug (or "drug principle") and with no duplicate inclusion of different salts or other variants of the basic drug. For most of the listings, there is a brief description, a statement of (though not a critique of) actions and uses, plus warnings about side effects and a note as to administration and available preparations.

The monographs, for some of the drugs, seem a bit too laconic, but the editors do not want to usurp the practitioner's judgement. At any rate, this is an exceedingly useful compilation, inexpensively priced, and readily portable. It can fit into your doctor's bag (if any of you still make calls) or into your side-pocket. It is a good companion to have readily available.

HENRY A. DAVIDSON, M.D.

Modern Treatment (Vol. 6, #2): Treatment of Obstructive Pulmonary Insufficiency, Edwin R. Levine, M.D., Editor; **Treatment of Lymphedema,** Alexander Schriger, M.D., Editor. New York, 1969, Hoeber Medicine Division, Harper and Row. Pp. 428 ($16 per year by subscription)

With its companion volume on restrictive pulmonary insufficiency, this is one of the most complete and comprehensive texts dealing not only with treatment but with the pathophysiology of respiratory insufficiency. Each author, from the initial chapter by Motley (discussing the basis derangements in obstructive disease with a concise presentation) through Dr. Gray's excellent chapter on *cor pulmonale* (with the differentiation of cardiac and pulmonary dyspnea), Tomasheski's report on acid base derangements with excellent tables, Seigal's discussion on asthma, Levine's detailed review of emphysema, Dine's discussion of drugs (particularly with an account of detailed side effects plus a discerning chapter on dispelling the myths regarding the use of certain ineffective drugs), and ending with Levine's complete and detailed discussion of aerosol therapy, makes this volume particularly valuable to all students of pulmonary disease. Of all the books in this field, these two monographs come closest to being the complete respiratory clinical guide.

The second part of the monograph is a symposium from the Mayo Clinic on lymphedema. The contributors have had great experience with the medical and surgical aspects of the disease as well as the important social-economic and rehabilatative aspects not usually discussed. It begins with an excellent introduction, proceeds to describe the details of lymphography with an excellent differential diagnosis of primary and secondary lymphedema with emphasis on the role of infection including fungus disease. This symposium is a welcome edition to previous work in this field.

ELLIS P. SINGER, M.D.



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It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

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Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraceptian.

Contraindications—Thrombaphlebitis, thrambaembalic disorders, cerebral apoplexy ar a past history af these canditians, markedly impaired liver functian, knawn ar suspected carcinama of the breast, known or suspected estragen-dependent neaplasia, undiagnased abnormal genital bleeding.

Warnings—Watch far the earliest manifestatians of thrambatic disorders (thrambaphlebitis, cerebravascular disorders, pulmanary embalism, retinal thrambasis); if present ar suspected discantinue the drug immediately.

British studies reparted in April 1968[1,2] estimate there is a seven- ta tenfald increase in martality and morbidity due to thrambaembalic diseases in women taking aral contraceptives. In these cantralled retrospective studies, invalving 36 reparted deaths and 58 haspitalizatians due to "idiapathic" thramboembalism, statistical evaluatian indicated that the differences observed between users and nan-users were highly significant. The canclusians reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

Na camparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk ta the individual patient, cannat be applied directly ta women in ather cauntries in which the incidences af spantaneausly accurring thramboembalic disease may differ.

Discantinue medicatian pending examinatian if there is sudden partial ar complete lass af visian, ar sudden anset af praptasis, diplapia ar migraine. Withdraw medicatian if papilledema ar retinal vascular lesions are faund.

Since the safety of Ovulen in pregnancy has nat been demanstrated, it is recammended that pregnancy be ruled aut far any patient wha has missed twa consecutive periads before continuing the cantraceptive regimen. If the patient has nat adhered ta the prescribed schedule the passibility af pregnancy shauld be considered at the first missed periad.

A small fractian of the harmane agents in oral contraceptives has been identified in the milk af mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.



Precautions—Pretreatment physical examinatian shauld include special reference ta the breasts and pelvic argans, and a Papanicalaau smear.

Endacrine and passibly liver function tests may be affected by Ovulen. Therefare, it is recammended that such tests if abnarmal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibramyamas may increase in size under the influence af pragestogen-estrogen preparatians.

Because these agents may cause some degree af fluid retention, canditians which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac ar renal dysfunctian, require careful abservatian.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nanfunctianal causes. Adequate diagnastic measures are indicated in undiagnased vaginal bleeding.

Carefully observe patients with a history af psychic depressian and discantinue the drug if severe depressian recurs.

Any passible influence af prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic ar uterine function awaits further study.

A decrease in glucase tolerance has accurred in a significant percentage af patients an aral cantraceptives. The mechanism of this decrease is abscure. Far this reasan, diabetic patients should be abserved carefully while receiving Ovulen.

Because af the effects of estragens an epiphyseal clasure Ovulen should be used judiciausly in yaung patients in whom bane grawth is nat complete.

The age af the patient canstitutes na absalute limiting factar, although Ovulen therapy may mask the anset af the climacteric.

The pathalagist shauld be infarmed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciatian has been shown between use af aral cantraceptives and the following serious adverse reactians: thrambophlebitis, pulmanary embalism.

Although available evidence is suggestive af an assaciatian, such a relatianship has been neither confirmed nor refuted far the fallawing serious adverse reactians: cerebravasculer accidents, neuro-ocular lesians, e.g., retinal thrambosis and aptic neuritis.

The fallawing adverse reactions are knawn ta accur in patients receiving aral cantraceptives: nausea, vomiting, gastraintestinal symptoms (such as abdaminal cramps and bloating), breakthrough bleeding, spatting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma ar melasma, breast changes (tenderness, enlargement, secretian), change in weight, changes in cervical erasian and cervical secretians, suppression af lactatian when given immediately post partum, chalestatic jaundice, migraine, allergic rash, rise in bload pressure in susceptible individuals, mental depression.

Although the fallawing adverse reactians have been reparted in users af aral cantraceptives, an association has been neither confirmed nar refuted: anavulatian past treatment, premenstrual-like syndrame, changes in libida, changes in appetite, cystitis-like syndrame, headache, nervausness, dizziness, fatigue, backache, hirsutism, loss af scalp hair, erythema multiforme and nadasum, hemarrhagic eruptian, itching. The fallawing labaratory results may be altered by aral cantraceptives: hepatic functian: increased sulfabramaphthalein and ather tests; caagulatian tests: increase in prathrambin, Factars VII, VIII, IX and X; thyraid function: increase in PBI and butanal extractable pratein baund iadine, and decrease in T^3 uptake values; metyrapane test; pregnanedial determinatian.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

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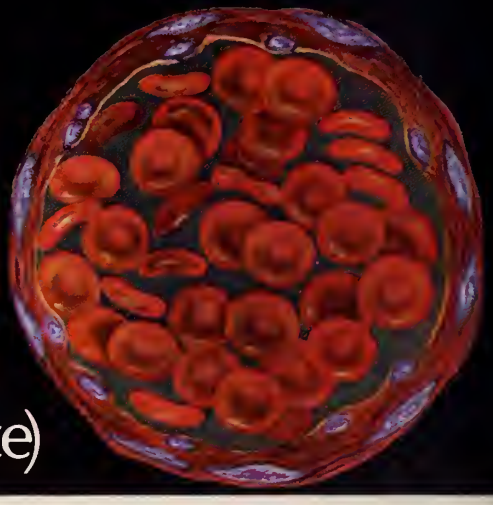
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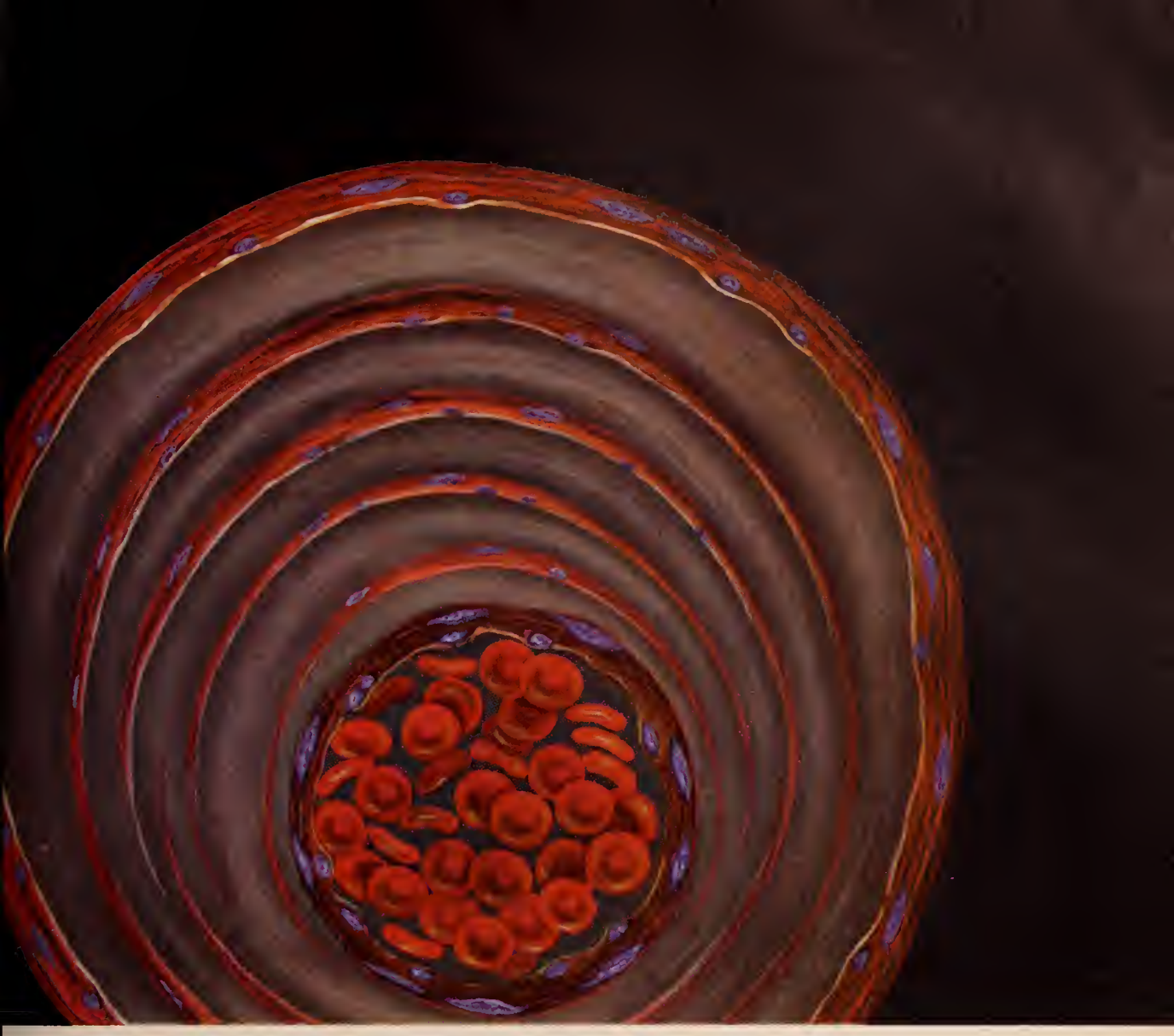
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Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

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Food 'n mouth disease

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reludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

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arning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

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Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

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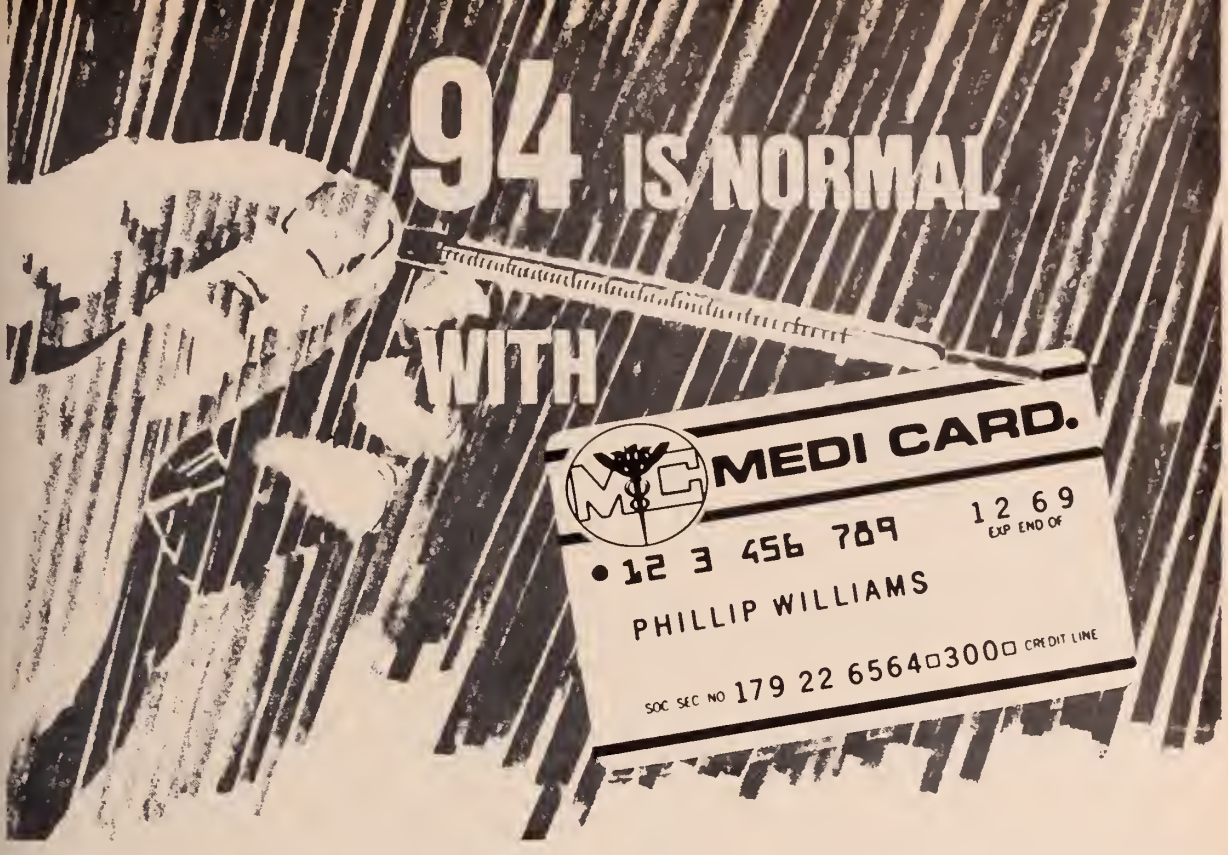
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(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

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PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

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Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
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Dose: 1 tablet 3 times daily.
Available:
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Each red tablet contains:
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Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
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Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
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Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
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also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride .... 10 mg.
Glutamic Acid ..... 50 mg.

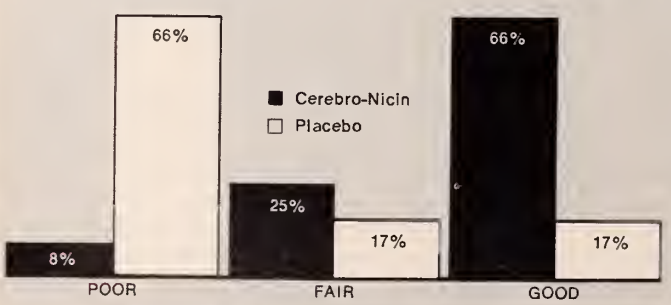
INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

For the treatment of the aging patient

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capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.

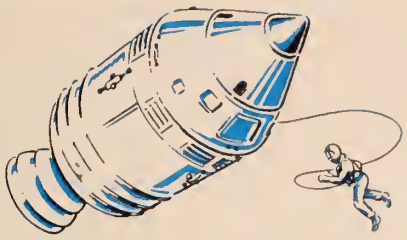
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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Man in space, naw fait accampli, re-emphasizes the importance af Ura-Phasphate therapy. Research inta the effect af space travel an the astranaut reveals that weightlessness causes lass af bane calcium. As the banes are required to bear less and less af the weight af the body they lase calcium, increasing the calcium cantent af the urine. When physical activity is reduced, the acidity af the urine shauld be adjusted ta keep increased calcium in salutian . . . . a praphylaxis ta prevent kidney ar bladder calculi.

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NOW A SUGAR-COATED TABLET

Each tablet cantains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

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Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

Far pratection af the inactive patient 1 ar 2 tablets every 4 to 6 hours is usually sufficient ta keep the urine clear, acid and sterile.

2 tablets an retiring will keep residual urine acid and sterile, cantributing ta camfort and rest.

A clinical supply will be sent ta physicians and haspitals an request.

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but it's not ACHROMYCIN® V
Tetracycline HCl

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250 mg. and 100 mg. capsules

ntraindications: Hypersensitivity to tetracyclines.
arning: In renal impairment, since liver toxicity is possible, wer doses are indicated; during prolonged therapy nsider serum level determinations. Photodynamic action to sunlight may occur in hypersensitive persons. hotosensitive individuals should avoid exposure; scontinue treatment if skin discomfort occurs.
recautions: Nonsusceptible organisms may overgrow; treat perinfection appropriately. Tetracycline may form a able calcium complex in bone-forming tissue and may use dental staining during tooth development (last half of regnancy, neonatal period, infancy, early childhood).

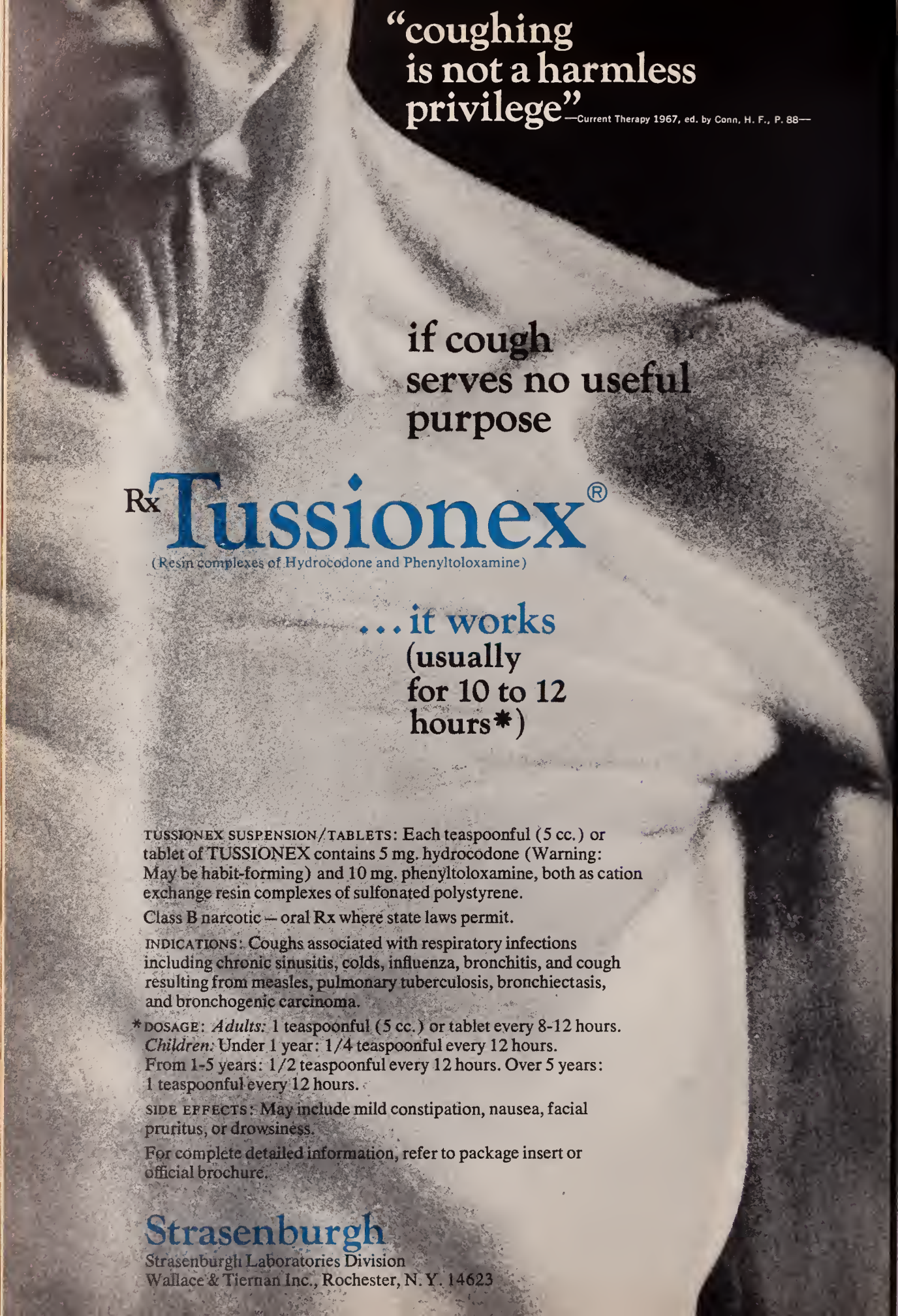
Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

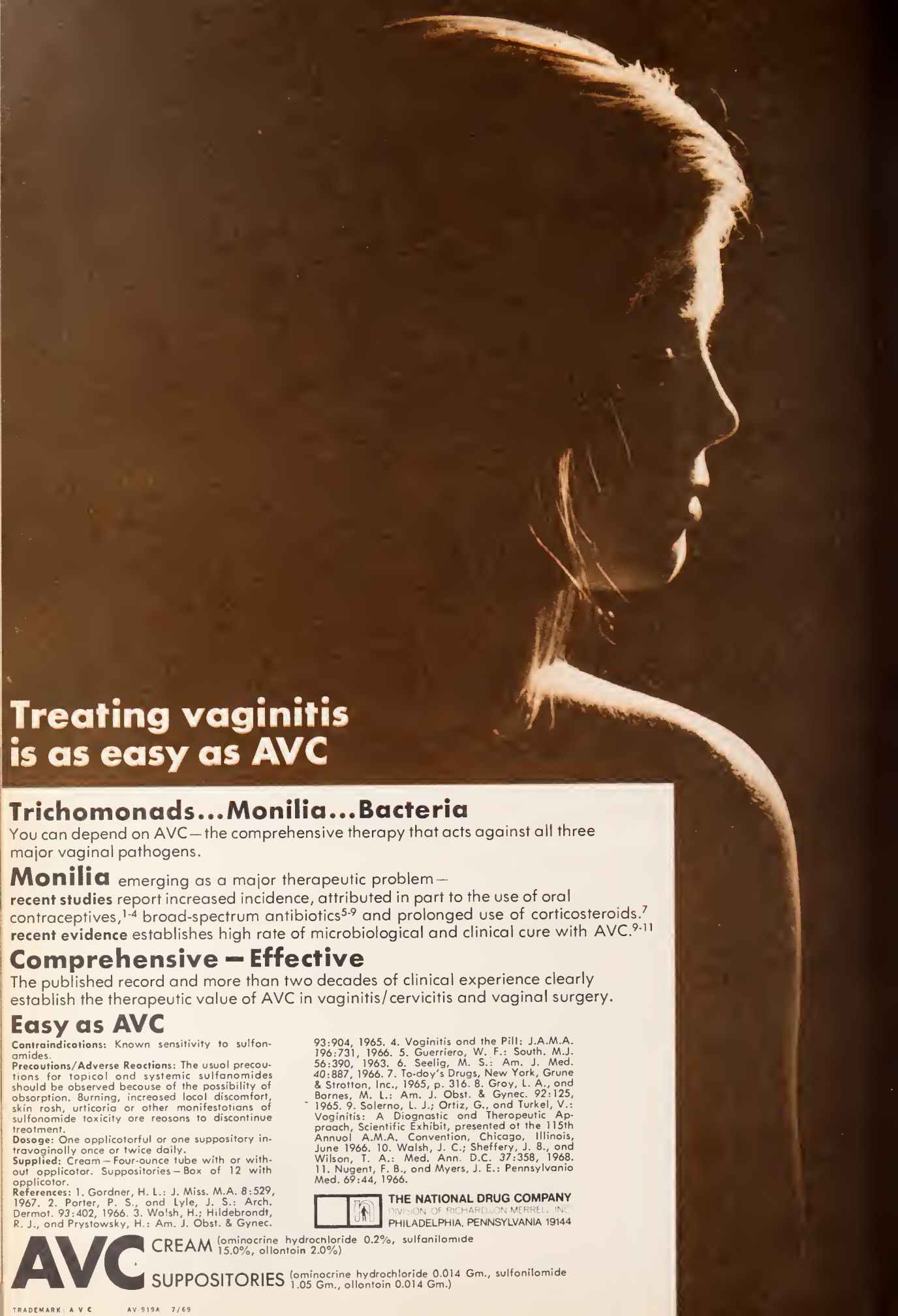
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Informotion—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indicotions:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Controindicotions:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precoutions/Adverse Reoctions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosoge:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

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(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

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You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
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The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

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Contraindications: Known sensitivity to sulfonamides.
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Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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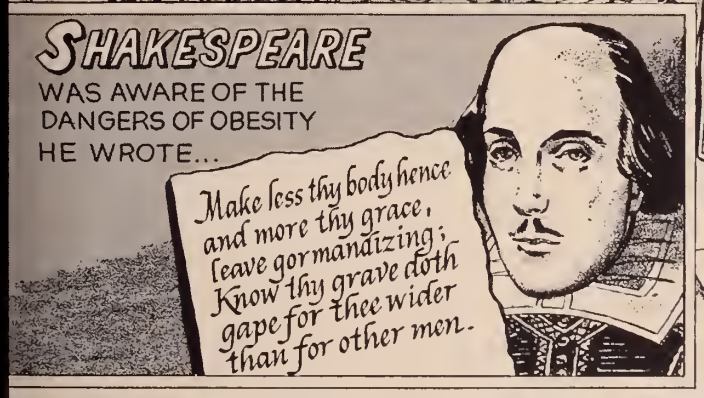
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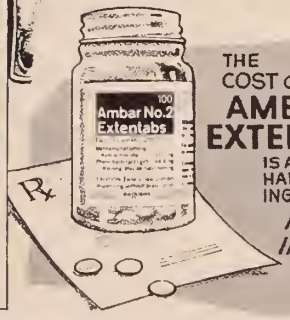
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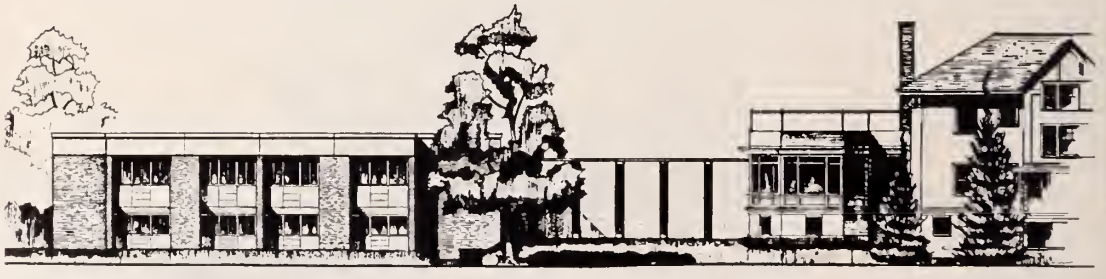
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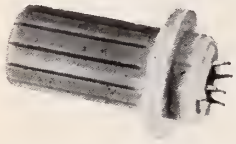
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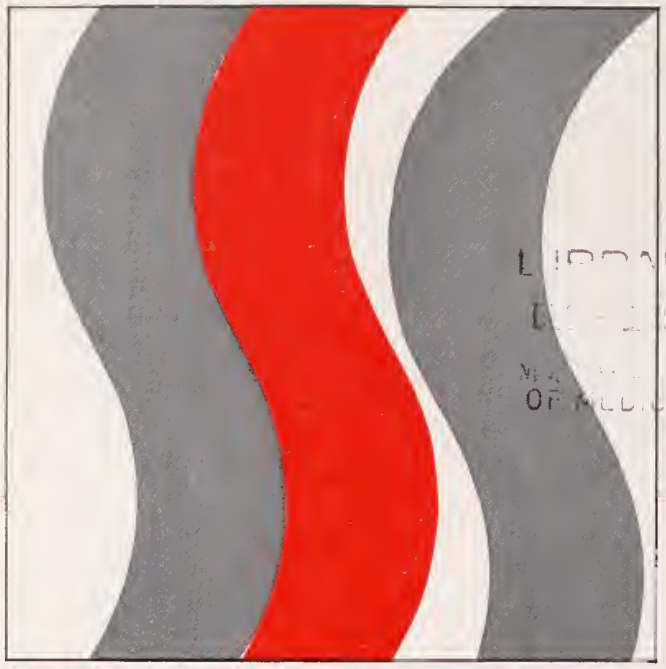


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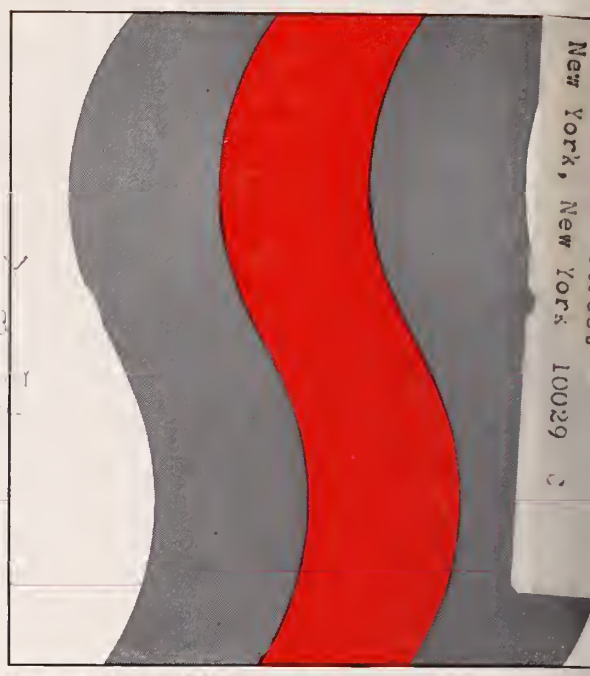
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Warnings: Caution patients about possible combined effects with alco and other CNS depressants. As with all CNS-acting drugs, caution pati against hazardous occupations requiring complete mental alertness (e. operating machinery, driving). Though physical and psychological de- pendence have rarely been reported on recommended doses, use cauti administering to addiction-prone individuals or those who might incre dosage; withdrawal symptoms (including convulsions), following disc tinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed ag its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, lim smallest effective dosage (initially 10 mg or less per day) to preclude a or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommende combination therapy with other psychotropics seems indicated, careful consider individual pharmacologic effects, particularly in use of potent drugs such as MAO inhibitors and phenothiazines. Observe usual pre- cautions in presence of impaired renal or hepatic function. Paradoxica reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. E usual precautions in treatment of anxiety states with evidence of impe ing depression; suicidal tendencies may be present and protective mea necessary. Variable effects on blood coagulation have been reported v rarely in patients receiving the drug and oral anticoagulants; causal re tionship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, espec in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the l dosage ranges. In a few instances syncope has been reported. Also en countered are isolated instances of skin eruptions, edema, minor mens irregularities, nausea and constipation, extrapyramidal symptoms, inc and decreased libido—all infrequent and generally controlled with do reduction; changes in EEG patterns (low-voltage fast activity) may opp during and after treatment; blood dyscrasias (including agranulocytos jaundice and hepatic dysfunction have been reported occasionally, m periodic blood counts and liver function tests advisable during protrac therapy.

BALCONY

the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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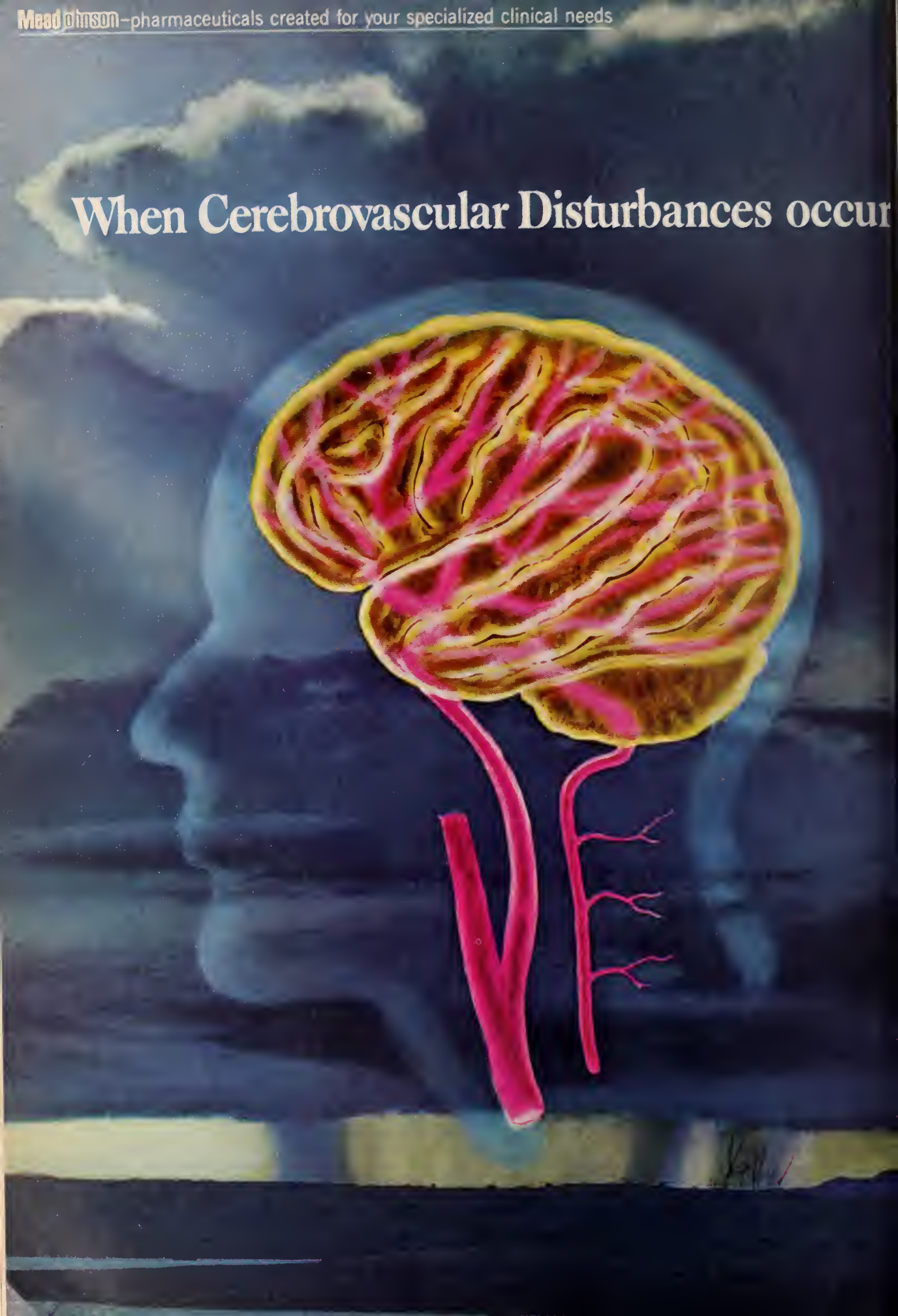
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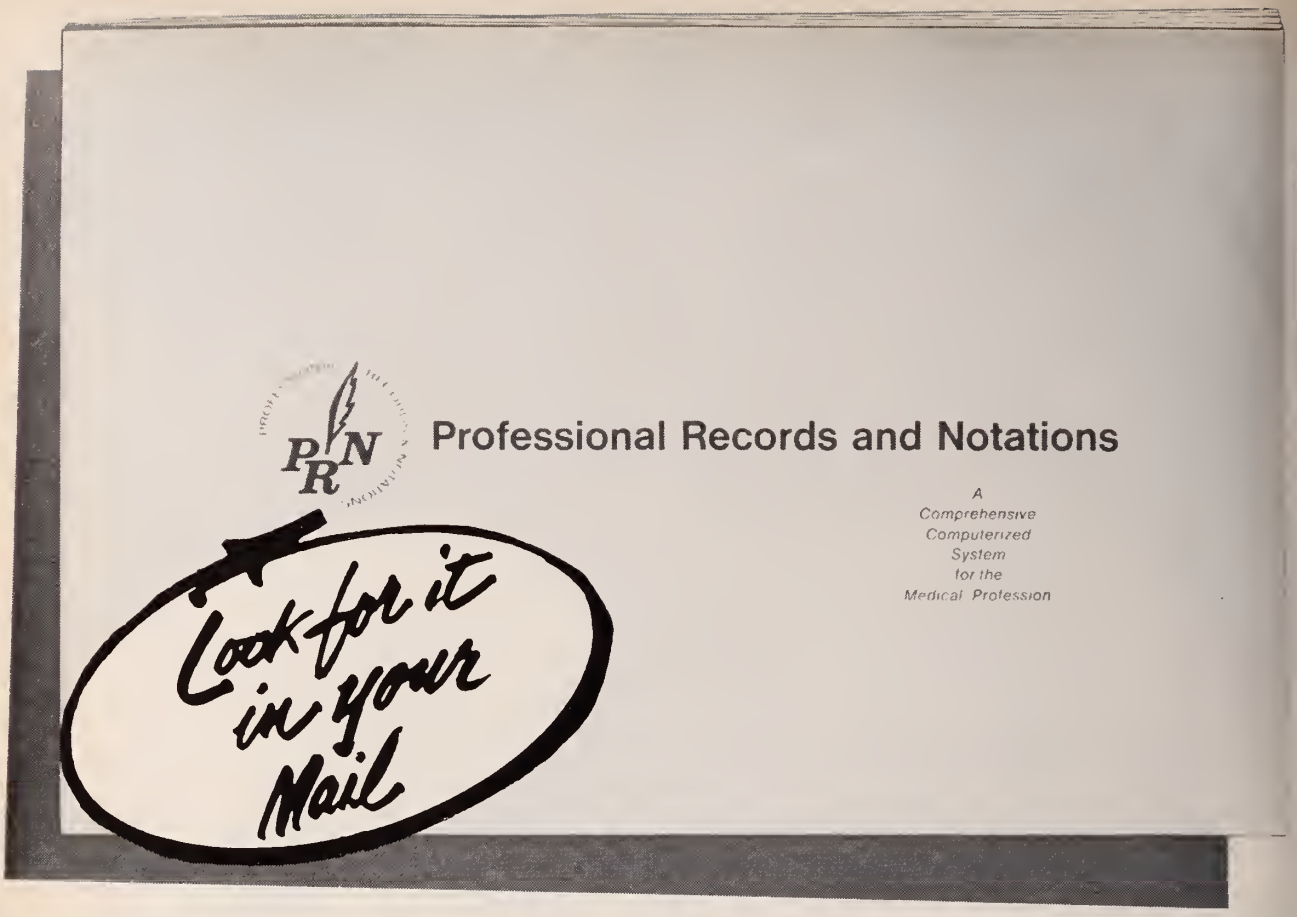
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Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

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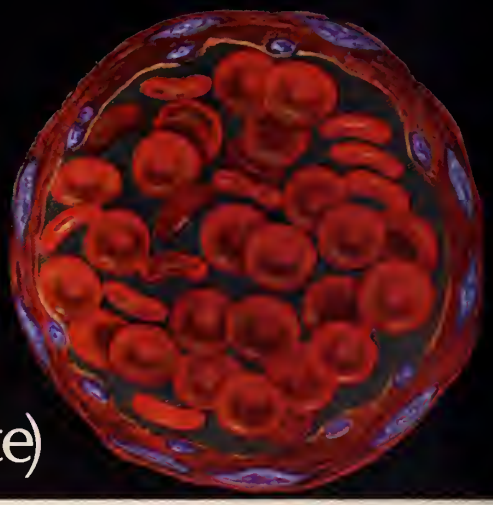
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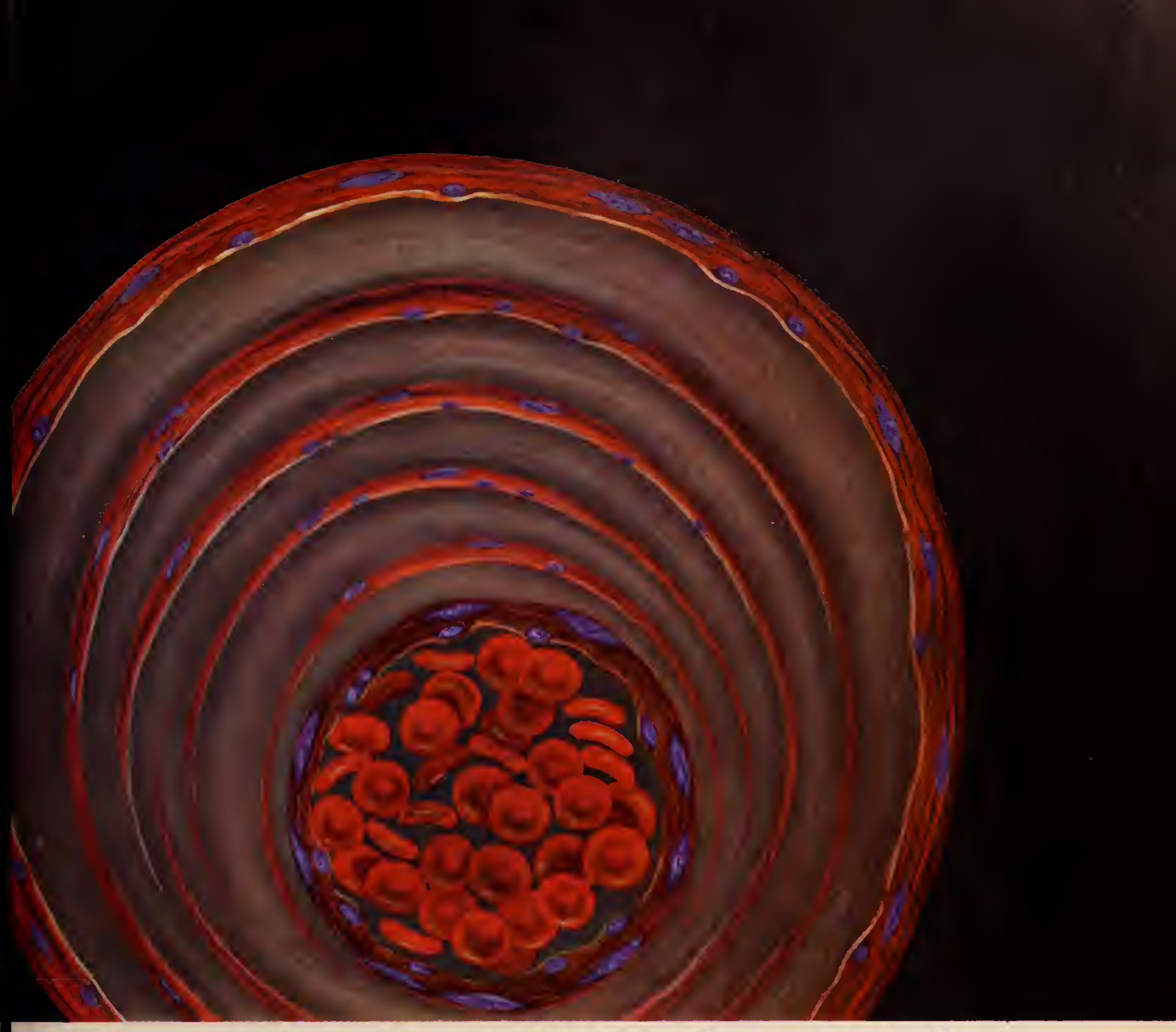
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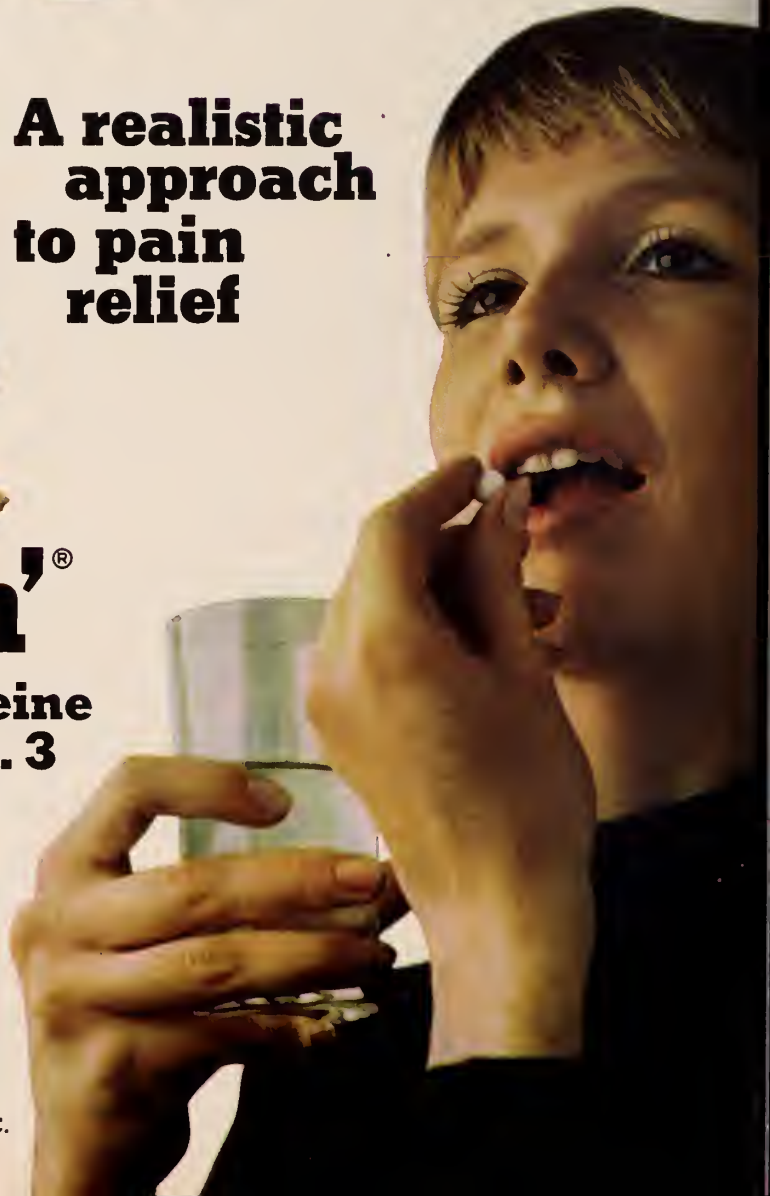


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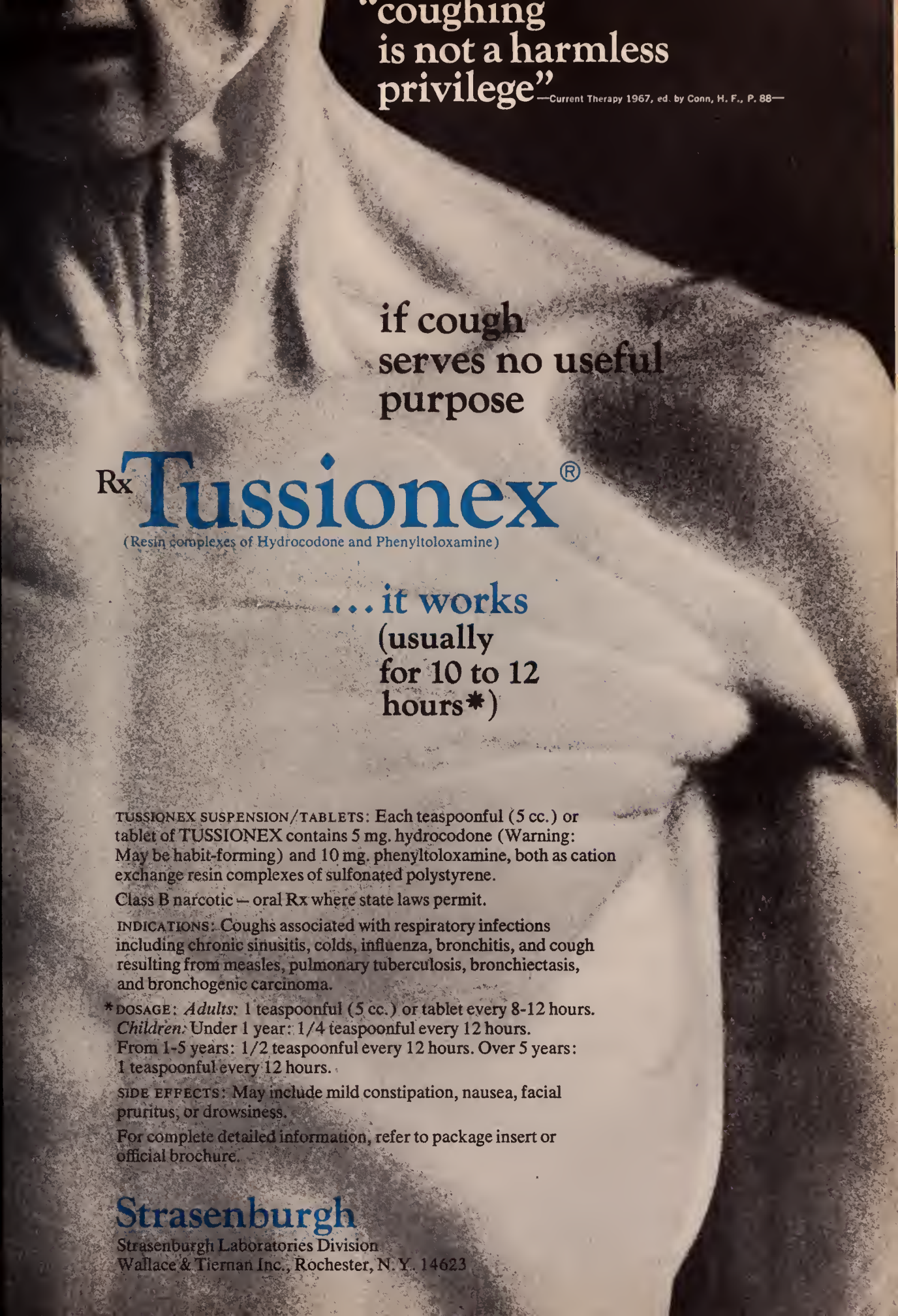
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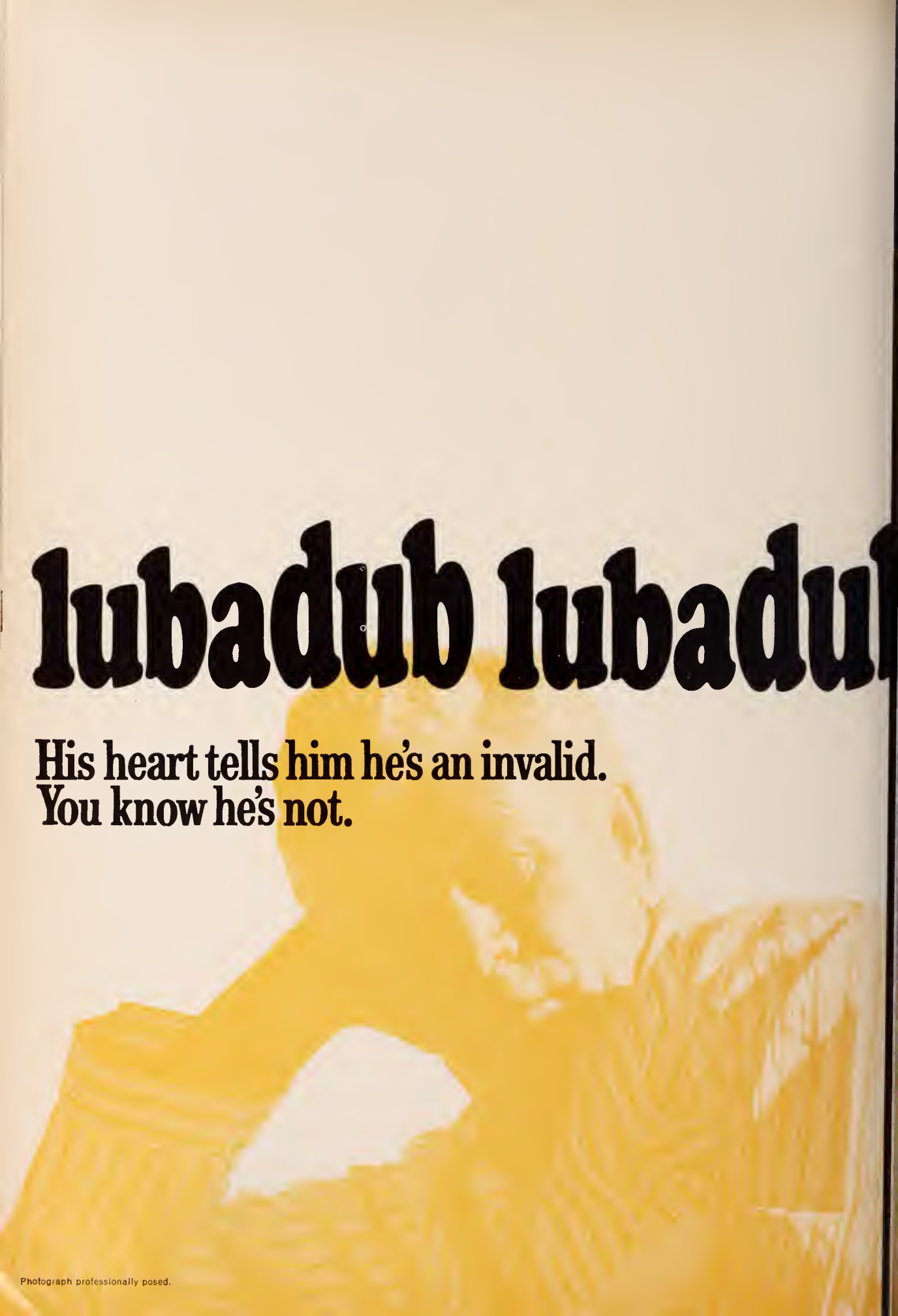
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Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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iety is expected in the cardiovascular patient.
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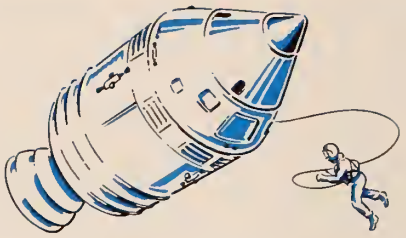
when anxiety is exaggerated . . . when it
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EDITORIALS

The Fall And Rise Of The Autopsy

When the seniors among us were junior medical students, the autopsy was a prime and glamorous educational tool. In spite of the morbidity of the subject, a kind of romantic image clung to it. Eager doctors of all ages crowded around the postmortem table, and the officiating pathologist dug deep and came out with an organ. And there, for all to see, was the mysterious lesion, the disorder that the clinicians had missed! It practically called for applause. And in the 1920s and 1930s, in many a hospital, the loud-speaker called for Dr. Mortimer Post or the electronic call board flashed 13, summoning all interns, residents, and available attendings to the autopsy room.

Time, alas, has rubbed much of the glamor off this picture. For the most part, autopsies are now conducted with a small gallery, or indeed, with no on-lookers at all. The sophisticated clinician says that really significant lesions are visible only by microscope, so that the pathologist isn't going to pull any visible rabbits out of *that* hat. Anyway, most of the time we know the cause of death without a postmortem. (Malignancy, or cardiovascular disease, that's what). So the once dramatic art of the public postmortem, the craft of confounding the clinician appears to have become less exacting and less exciting.

But slowly some second, or third, thoughts are developing about the necropsy. In the first place, the accuracy scores of many able clinicians are not what they should be. So far, no computer, no clinical hunch, no test in the clinical laboratory, has come near to matching the postmortem in spelling out the exact diagnosis. Such new activities as organ transplants and their failures have lent a special value to autopsies. Then, too, the museum of anatomic and pathologic material still remains as the world's most valuable goldmine for correlating disease with clinical symptoms. And the research opportunities of the autopsy are staggering.

One wonders if some of the drifting away from interest in autopsies is not due to the habit so many hospitals have of tucking the "post" room into a cellar as if they were ashamed of it. Why not do autopsies in a centrally placed chamber in the mainstream of hospital traffic? Why not schedule these examinations at hours of maximum staff convenience? An appointment system for postmortems may sound silly — but why not? When all is said and done, if the undertaker is the last man to let us down, surely the pathologist — let's call him the autopsy surgeon — should have the last word. Although the metaphor sounds a bit strained, we suggest that the necropsy is due for a renaissance.

The End Of Learning?

When the chief reached the age of 65, they gave him a dinner on his retirement from active hospital service (and his eligibility for Medicare). It occurred to his 50 year old associate, that the chief really wasn't going to learn much from here on in. Suppose they did give a course on medicine for the space age (or the special medical requirements of men on the moon) would the chief have the interest or ability to learn, in real depth, about the effect of lessened gravity on the pH of the circulation of the blood? The chief knew he would never get out of the 20th century alive.

The chief was in one of the surgical specialties, but he had to retire from active operating room work and would never again stand at the number one position at the table. So why should he learn a new way of anastomosing blood vessels? He'd never use it. Could he learn about the "effects of changes in electrolytic fluid balance on osmotic pressures within the renal tubules?" Or the "deeper microphysiology of immunologic reactions with reference to organ transplants?"

Could a doctor at the end of a busy career of active practice learn new things like that? The answer is: you bet he can. It means reading a lot, going to medical meetings, listening to the speakers instead of swapping nostalgic anecdotes in the lobby and even digging in and doing a lot of studying. But the intelligence and experience are there. All that is needed is motivation. The end of active hospital service need not mean the end of learning.

Lies Can Save Lives

Every doctor knows that on certain occasions telling the patient the truth may plunge him into a depression, drain out his will to live, destroy his morale, or precipitate a suicide. The phrase "to tell a lie" sounds ugly and sinful. We prefer to evade this by explaining that the issue is not "to tell lies" *vs.* "not to tell lies," but rather one of how much wisdom and discretion to use in explaining the truth. Or, it may be balder than that. Sometimes the patient asks a blunt question and either the doctor tells a painful truth or a saving — and salving — lie.

You seldom see any great controversy on telling the truth about heart disease, though heart disease kills more people than cancer. The distinction here seems to be semantic rather than medical. We can speak of coronary episodes in the past, implying that they are over — "You had a coronary attack," with the emphasis on the *had*. But cancer is always thought of in the present tense. Yet this need not be so. Cancers have been removed with no recurrence and no metastasis. The number of such permanent cures is increasing every year. Still the *word* remains — not a label but a doom.

Here is a woman with a rodent ulcer of the lip. Is this cancer? Yes, it is. But the prognosis is excellent and what possible good would it do the patient to tell her she has a cancer? The only criterion of a medical action is the patient's welfare. This is not served by pronouncing words of doom when the chances are the patient will recover from the lesion. Tell her that she has cancer, and — no matter how optimistic and casual you are — she will suffer an irreparable emotional trauma, which may lead to anything from depression to suicide. The rodent ulcer used to be called *noli me tangere*. Perhaps today, *noli me dicere* would be better.

But, you say, you have stacked the argument by selecting the one malignancy with a high cure rate. The prognosis from cancer is improving year by year. Cases with a fair outlook are more common. Also, the number of years of living — not just vegetating, but, if you please, the good life — after diagnosis, can be substantial. Every doctor knows of carcinoma victims who have lived for 3 or 4 years and then died of coronary attacks. A person can (sometimes) live longer with a myelocytic leukemia than with some nonmalignant diseases. And every practitioner can name some patients, who, in all logic, should have been dead three years ago and who continue to survive — sometimes fairly actively — as if there were some secret well spring of life force somewhere in the body.

The man of affairs should have time to get his business in order if death seems likely. This can be tactfully handled by having such a patient reduce his business activities in order to get the necessary prolonged rest, or to accomplish a more tranquil life. It can be put to him on that benign basis. Hope and faith are powerful medicines. Their tonic effects on body metabolism have often fought off disease for many years. Death always wins in the end, of course. But our job as doctors is not to defeat death — none can do that — but simply to postpone his visit. And here faith, hope, reassurance, and tranquility are our allies. On the other hand, death is hastened by fear, demoralization, and hopelessness. It is a sin to tell a lie; but a man does not practice medicine simply to save his own soul. He has a sworn duty to help his patients. So if the lie will save lives, let it be told. Human life is so important in the eyes of God, that surely He will forgive so venial a sin for so precious a purpose.

ORIGINAL ARTICLES

The plastic surgeon must assess psychological motivations as well as physical reasons for plastic surgery.

Psychology Of The Prospective Plastic Surgery Patient*

Daniel L. Goldstein, M.D./Hackensack

Few areas in medicine present a greater interplay between psyche and soma than the field of plastic and reconstructive surgery. Physical deformity has a different emotional meaning to each individual. The same deformity may have a different meaning to different patients or to the individual patient and to the treating doctor. Difference in meaning may play a crucial role in the ability of the plastic surgeon, with his fine and consummate skill, to help a troubled patient.

Basic to the problem is the self or body image that the patient has developed. One's concept of his body is not innate. It develops early in life as a result of a multitude of sensory impulses impinging on the cerebral cortex. From early infancy, a human develops a picture of his physical being from visual, tactile, oral, auditory, and kinesthetic senses. Once this is established, it becomes a framework of reference for him and acquires profound emotional significance. With the growth of the individual in size and shape and with evolving capacities for intricate motor activities, the body-image is continuously modified. The progressively developed images of the body and the body parts remain as memory traces within the nervous system and reappear in states of neurologic dissolution or psychological regression, as clinical observations have demonstrated.[1] Furthermore, the character or quality of the body-image is also a function of one's socialization experiences. Socially determined qualities begin to appear with one's earliest experiences in relation to the significant persons in family or home. The attitude of the parents imparts an indelible impression on the child's concept of himself and his body. Depending on the experiences with the parents, the body and parts may be conceived of as good or bad, pleasing or repulsive, clean or dirty, loved or disliked.[2] Certain aspects of body development tend to be prized, while others are derogated. Strength and prowess may be emphasized in boys and men, with major investment in the development of strong limbs. In a similar manner, aspects of body-image may be emphasized as qualities of beauty in girls and women. Derogating attitudes with overcompensatory mechanisms frequently develop to obscure actual or fancied defects, if the child is made to feel that his body fails to meet the expectations of those about him. When families exploit the significance of appearance, overevaluation and reliance upon security through bodily beauty follows.[3]

Reactions to Defects

The attitude of society toward physical disfigurement is generally that of rejection or repulsion. The deformed child is rejected on grounds that his deformities are due to "sins of the father," "punishment for wrong doing," and so on.

Macgregor, *et al.*[4] described several types of reactions: (1) denial of defect; (2) hiding of

* Read before the Section on Plastic and Reconstructive Surgery, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1969.

defect; (3) symbolic denial, as by encouraging display but discouraging discussion of defect; (4) undoing, that is fostering the belief that the disfigurement was a distinction; (5) normal behavior with open discussion of the defect and the realistic concern it caused parents and child. The mother's unconscious anxiety may communicate itself to the child. The ignoring of the defect by the family may be felt by the child as a derogating attitude on the part of his family. His rejection by the family may be more crippling than the defect itself. He will then have deficiencies that a plastic surgeon cannot correct. Here the answer will have to be psychiatric intervention.

A change in body-image always arouses anxiety in the patient. Defenses against the anxiety include:

(1) It may be projected as hostility and rage toward others with a wish that they too be deformed, with the attendant guilt feelings.

(2) Depressive reactions are common with a fear of rejection by others.

(3) The defect may be seen as a just punishment for wrongdoing.

(4) There may be changes in the relationship with others, such as withdrawal; hostility expressed by rudeness and curtness; overt flaunting of the defect, daring people to react to it; or concealment of hostility by being overly concerned about his attitude toward other people.

Evaluation of Prospective Candidates

Taylor, *et al.*[5] have stated that "the favorite patient of the plastic surgeon is one whose disfigurement has become a major obstruction to happiness and whose personality responds with definite improvement when correction is accomplished. But there is the kind of patient whose minor or even imaginary disfigurement has become, in his eyes, the cause of all his failures, the reason that he cannot get along with people and that nobody likes him. He expects that with correction of the defects all problems will disappear and that he will be loved and respected. The same personality, however, remains inside the altered envelope of skin, and when the fulfillment of expectations is not forthcoming, the failure must be attributed to the deficiency of the operation and the fault of the operator."

Young Children

Macgregor[6] concluded that if elective surgery cannot be done within the first years of life, it may best be postponed until the child can understand what is said to him. Detrimental consequences seem to occur if the deformity persists into puberty. It is necessary to deal with the relationship between child and parent and the parents' attitude to the defect in order to avoid a persistence of personality disability even after successful surgery has produced an excellent result.

Knorr, *et al.*[7] have recently reported a ten year survey of cosmetic surgery of adolescents at Johns Hopkins University. The procedures included 26 rhinoplasties, 11 augmentation mammaplasties, 8 dermabrasives for acne, and 11 otoplasties. The patients ranged in age from 14 to 21 with a preponderance of females. They pointed out that physical changes *via* cosmetic surgery are more easily integrated by the adolescent, and that postoperative emotional disturbances and identity crises are of less frequency and severity than those encountered in adults. They found that few grossly immature or unstable adolescents ask for cosmetic surgery. Occasionally, an adolescent with weak ego strength has a severe postoperative emotional reaction. But they find that often patients who are psychotic or neurotic may benefit from cosmetic surgery. The important feature in the evaluation in psychiatrically ill patients is determining whether the request for surgery involves magical or delusional thinking. The paranoid patient is a poor risk. They emphasize the role of psychiatric collaboration in the clinical management of adolescents. Psychotherapy, they feel, is rarely indicated as an alternative to surgery. Psychotherapy, however, may help to clarify the patient's expectations and motivations.

Adults

The conscious and unconscious motivations of patients for cosmetic surgery must be

studied as a background to understanding. We all use symbols, consciously and unconsciously, in dealing with important emotional issues.

Females

Meyer, *et al.*[8] reported on a three year study of women from ages 14 to 43 seeking rhinoplasty. They found in all these, that self conscious preoccupation with the nose (as "ugly" or "inappropriate") dated from adolescence. The motivation varied with age but included cultural conflicts and the wish to avoid stereotypy as an "alien;" ambivalent and intensely conflicted parental identification with resulting attitudes particularly restrictive in the area of expression of feminine and sexual attractiveness; and in older women, active interpersonal stress.

The operative procedure functions symbolically as a disavowal of the restrictive aspects of parental identifications and an active striving toward greater comfort in the feminine role. Adolescence is regarded as crucial in confirming the defensive use of feelings of the deformity of the nose in the attempted mastery of conflicts.

Male

Jacobson, Edgerton, *et al.*[9] reported in another study at Johns Hopkins on a series of male patients who sought cosmetic surgery. This group showed interesting and consistent patterns differing from those of women. The men had minimal deformity with no residuals of trauma or major congenital malformation and whose complaints were of a cosmetic nature related to the face.

The general psychiatric impressions[10] were as follows: "As contrasted to the female rhinoplasty patient who has been described as plain, rigid, awkward, tense, and shy, the model male patient may be forlorn and guarded. He is exaggeratedly relaxed. His voice is soft. His affect one of worried awareness, lacking in vigor. He is humorless and preoccupied. He expresses a sense of urgency common to all cosmetic patients." They said that, as a group, *all were seriously ill emotionally*. All had major problems about heterosexual effectiveness. Here are their conclusions:

1. The male patient seeking cosmetic surgery for mild or minimal congenital deformity is likely to have serious emotional illness.

2. He often has a family background of cultural experience that conflicts with his present family and cultural circumstances.

3. He is usually in a life situation challenging to his masculine effectiveness, or is contemplating re-entering a competitive situation.

4. His health and social patterns are usually adequate.

5. He often has marked difficulties in heterosexual adjustments.

6. He has had a difficult problem in identifying with his father. Failure in this identification has hindered him in mastering his intensely ambivalent relation with his mother. Indeed, his surgical quest may represent an active struggle to free himself from the ambivalent relationship with women and his identification with his mother.

7. Results of cosmetic surgery are subjectively satisfying to carefully studied patients and lead to modest to minimal improvement in over-all effectiveness in living.

8. Surgery should not be performed during a major life crisis.

9. Covert or overt expectations that the operation will help by changing others should make the plastic surgeon cautious about operating.

10. In view of the difficult personality problems and likelihood of minimal success, psychiatric consultation is advised for the male patient seeking cosmetic surgery.

11. Every male patient seen by the plastic surgeon will obviously not need a psychiatric consultation; but many will be helped if the surgeon assumes the responsibility of guiding his patients toward optimum medical care. A psychiatrist experienced in the nature and possibilities of plastic surgery is more likely to be of real help to the plastic surgeon than one without this background.

Clinical Observations

I here present, briefly, two patients of my own. One underwent rhinoplasty as an incidental procedure in the course of long term intensive psychotherapy. The other was seen in emergency consultation a short period of time after her rhinoplasty. Both are women. One was 46 years old. She first sought psychiatric help at the age of 29 for a sexual problem. She was married and after one year

in psychoanalytic therapy she became pregnant, was delivered of a male child, and then developed a post-partum psychosis for which she was hospitalized for nine months. Diagnosis was schizophrenia, paranoid type. I saw her following her discharge from the hospital at which time she was much improved. She entered into intensive psychotherapy with me but progress was slow.

The patient was and is an extremely attractive woman with fine features and a nose that needed little improvement. However, since adolescence she had been preoccupied with her nose and had always hoped to "have it fixed." She is outgoing and friendly. After two and a half years in therapy she felt ready and after brief consultation with a surgeon she had a rhinoplasty done. Her acute fears revolved around the anesthesia rather than the surgery itself. Since she needed little improvement preoperatively, the postoperative result was not remarkable. However, the patient was pleased with the result and had a very realistic attitude toward it. The surgery was a milestone in therapy. It gave her sufficient impetus to really move forward and she soon began to make real progress in a number of psychosocial areas.

The other was a 30-year old woman seen by me for an acute, severe depression with suicidal ideation, following rhinoplasty. She required immediate brief psychiatric hospitalization.

About nine months prior to her first psychiatric contact with me, she sustained a minor injury to her nose that subsequently remained extremely painful and interfered with her breathing. This injury had been received while playing with her infant son who "bumped his head into her nose." Her doctor recommended surgical intervention for a fractured nasal septum and simultaneously urged her to have her nose "fixed." She reluctantly agreed. She was 6 months pregnant at the time of the plastic surgery. Immediately following the "unveiling" of her new nose she became acutely depressed and preoccupied. She complained that her nose was markedly changed, and she refused to look at her face in the mirror. She said that she looked "artificial" and could never learn to live with it. Her preoccupation became an obsession. Her depression deepened. She became suicidal and was briefly hospitalized. In reality she was an extremely attractive woman — the change in appearance was minimal (although not for her). In my opinion there had been improvement if one compared her present appearance to the preoperative pictures.

During her hospitalization, the suicidal preoccupation receded although not the obsession about her nose. For financial reasons she was referred to a low cost psychiatric clinic. At this time I have no further information about her progress. I made a tentative diagnosis of an acute schizophrenic reaction following the rhinoplasty. Psychological testing done on the patient while she was hospitalized revealed her to be "hypochondriacal and defensive about her emotional problems." She uses somatic symptoms as a defense against psychotic thoughts. While she may respond readily to advice and reassurance she is hesitant to accept a psychological explanation of her difficulties. In times of prolonged emotional stress, she is likely to develop physical symptoms. She is particularly vulnerable to psychophysiological symptoms such as headaches, tachycardia, and gastrointestinal disorders. There are unusual qualities in this patient's thinking which may represent schizophrenic tendencies. Her interests are strongly masculine, and she may regard herself as unfeminine and unemotional. She may be hesitant to become involved in social relationships. She is sensitive, reserved, and somewhat uneasy, especially in new and unfamiliar situations. She may compensate by unusual conscientiousness in her work and other responsibilities. Although she may show a good response to short term treatment, her symptoms are likely to return rapidly.

Some Anticipated Postoperative Responses

Just as the patient's initial body-image response was in part determined by the reaction

of those around him so is his postoperative reaction affected. Even in the face of a good cosmetic result, considerable time may elapse before the patient can accommodate himself to his new features. Many complain that their expectations have not been reached. They had blamed their disfigurement for all social failure and are disappointed that complete acceptance is not immediately forthcoming. Patients with a healthy emotional attitude and unimpaired body-image are aided by surgery. Among those whose body images are vague or false, emotional difficulties tend to continue after surgery.

For the Surgeon's Guidance

As paraphrased from an article by Taylor, *et al.*[12] here are some ideas that might be useful in helping the plastic surgeon in selecting his patients. It is suggested that a surgeon refuse for surgery a patient who (1) has a long history of psychiatric difficulties prior to the occurrence of minor disfigurements, (2) has suspicious or paranoid ideas about his disfigurement — who thinks people are talking about him or laughing about him; who blames a lack of social acceptance and inferiority wholly upon the disfigurement, (3) has imaginary disfigurements, (4) is a male and wants surgery for minor disfigurements, especially if he wants to appear more feminine, (5) has already had several cosmetic operations for the same minor disfigurement, and especially if he feels that "you are the only surgeon that can help him," (6) expects perfection at the first operation, although informed that more surgery may be needed, (7) expects more than can be offered, (8) expects some specific, dramatic effect on someone else, (9) has unrealistic expectations of improvement in his personality, job, and emotional status.

In any event, the surgeon should (1) establish good rapport to help him judge when a psychiatric crisis may be imminent, (2) find out the goals expected by the patient, (3) inform the patient of the limitations of surgery, the extent and seriousness of preoperative, operative, and postoperative treatment, the possibility of failure and need for reoperation, and the amount of his fees and the other expenses, (4) obtain informed consent and record it in the patient's history; have a witness or have consent forms signed for all borderline cases; and have preoperative and postoperative photographs taken in all cases, (5) estimate the patient's capacity to withstand failure of the projected operation and obtain psychiatric assessment in questionable cases so that psychiatric care can be started before the operation rather than after, (6) stress that results should be improvement and not perfection, (7) inform the patient of postoperative discomfort and depression expected and the possibility of his relatives' disapproval, (8) inform the patient that the final results of most cosmetic operations are not apparent for months after surgery and (9) be prepared himself for periods of anxiety in the patient after the operation.

In reviewing the literature I was amazed with the infrequency with which postoperative psychotic reactions occur. Many psychologic and social advantages accrue from plastic cosmetic procedures. In our society a premium is placed on an attractive physical appearance.

The more realistic the defect and the more pressing the social needs (as in "show business" or in any situation where one deals closely with the public) the greater the likelihood of success, surgically and psychologically. Conversely the less prominent the defect and social handicap and the more subjective the need, the less there is the likelihood for success.

The surgeon, besides looking at the patient's motivations must also look at his own. He should question his own reasons for proceeding with any individual case. He should recognize that his own background, age, and experience and the value he places on esthetics are insistent influences upon his decision regarding the patient. Psychiatric consultation[13] has an important and useful function in assisting the plastic surgeon in his search for a satisfying result.

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90 Prospect Avenue

A Federal License For Drug Manufacturers?

Stricter legislation which would require drug manufacturing firms to obtain a *federal* license before beginning operations has been publicly called for by the outgoing chairman of the Pharmaceutical Manufacturers Association. Mr. Walter Munns told his association that he believed it is time that "the law be amended to require that every drug manufacturing establishment obtain a federal license before beginning operations."

Mr. Munns, who is Chairman of the Board of Smith, Kline, and French Laboratories, pointed out that under the present law *anyone can legally start a drug manufacturing business* and operate for two years before the Food and Drug Administration is required to inspect the plant and its operating procedures. "Obviously, in a period of two years a vast quantity of substandard, even dangerous drugs can be marketed. This is a real threat to the public health," said Mr. Munns.

"The law," added Mr. Munns, "should make it mandatory for the FDA to inspect every drug manufacturer at least once every year instead of the once-every-two-years required by the 1962 Kefauver-Harris Act."

He said that "henceforth a manufacturer should not be permitted to market a drug — new or old—sold either under a generic or brand name until he has established the therapeutic effectiveness of his particular product by substantial clinical evidence or, when appropriate, by assays in man that demonstrate the biologic availability of the active ingredients. It is ironic that the government's emphasis on 'generics' has overlooked the fact that countless drug products are on the market which have *never* been cleared by the FDA for safety and effectiveness, and, even today, manufacturers are under no compulsion to do proper testing before marketing many drug products."

Mr. Munns said, "If the government insists on setting prices for government drug programs on the basis of existing prices of the so-called generic equivalents, then it seems to me that actual therapeutic equivalency of such products should be established."

Wide resection of ovarian tissue is the treatment of choice in managing a case of Stein-Leventhal Syndrome.

Stein-Leventhal Syndrome

Ralph W. Ellis, M.D./Trenton*

In 1935 Stein and Leventhal described a clinical entity which has, since then, received wide recognition and acceptance. It is characterized by the onset of oligomenorrhea to amenorrhea, anovulation, and sterility in the normal menstruating female. It is associated with bilateral ovarian enlargement. On gross examination, the ovaries show a typical oyster shell color, produced by a thickening of the tunica albuginea. On cut section, multiple follicular cysts are noted, but no corpora lutea.

Specific etiology is unknown. The most accepted explanation is that there is an inadequate supply of L.H. (Luteinizing hormone) from the anterior pituitary. No ovulation occurs. Follicular stimulating hormone (FSH) continues to be secreted, producing many small follicular cysts, which lead to bilateral polycystic ovaries without corpora lutea or corpora albicantia. Another theory is that a thickening of the tunica albuginea has occurred preventing ovulation. Over-production of the adrenal steroids is seen associated with this condition but its relationship is not understood.

Other etiologic factors may be ovarian theca cell hyperplasia or pituitary basophilism with unopposed FSH secretion.

Generally noted are:

(1) *Bilateral ovarian enlargement.* This is basic and must be present for the diagnosis to be made.

(2) *Oligomenorrhea.* Widely spaced menses varying to amenorrhea—this is most consistent.

(3) *Anovulation and sterility.*

Also sometimes noted are: hirsutism, obesity, atrophy of breasts and uterine hypoplasia.

Table I
SEVEN CASES WITH RESULTS AFTER SURGERY

Age	*Symptoms*	*Date of Operation*	*Post-Operative Onset of of Menses (Months)*	*Pregnancy After Surgery*	*Comments*
27	Amenorrhea 3 months Obesity	1958	One	7/59 9/62 3/68	Repeat biopsy of ovaries at the time of C-section 9/62.
20	Amenorrhea 6 months	1965	Three	1/66	
19	Irregular menses	1962	Three	5/64	
27	Amenorrhea 3 months Obesity	1958	Three	12/64 9/66	
28	Period every 6 months	1966	Three	1/67	
27	Amenorrhea	1962	Five	3/66	Clomiphane® given.
28	Amenorrhea	1963	Four	9/67	

* From the Department of Obstetrics and Gynecology of the Mercer Hospital, Trenton. The pathological diagnosis is by courtesy of George Mora, M.D., of the Department of Pathology.

Laboratory studies should be conducted, and in the typical case these will result:

(1) Culdoscopy and gynography reveal evidence of ovarian enlargement.

(2) Vaginal smear shows an estrogen response.

(3) Endometrial biopsy indicates a proliferative endometrium.

(4) 17 Ketosteroids show normal to slight elevation.

(5) Basal temperature shows nomophasic type of curve.

(6) Urinary estrogens and B.M.R. should be normal.

(7) Cortisone suppression test gives no response.

Table II

MICROSCOPIC FEATURES OF STEIN-LEVENTHAL SYNDROME

1. Fibrous thickening of the cortex.
2. Multiple cortical follicular cysts.
3. Absent corpora lutea.
4. Absent mature follicular cysts bulging above the surface of the ovarian cortex.
5. Multiple corpora fibrosum.
6. Theca-lutein cysts.

Therapy is surgical with wide-wedge-resection and removal of one-half to two-thirds of the ovarian mass. Seventy-five to ninety-five per cent of patients menstruate regularly and sixty to ninety per cent conceive. Review the three tabulations on these pages. One represents a summary of the case histories and the second displays the microscopic characteristics of the syndrome. Table III reflects the gross and microscopic characteristics of the removed tissue. One patient required Clomiphane® for two months before conception occurred. Another showed evidence that recurrent fibrosis of the capsule may occur. This was made possible by biopsy at the time of cesarean section.

Seven cases of Stein-Leventhal Syndrome are presented. A discussion of the etiology, pathology, diagnostic criteria, and pregnancy results were noted. Wedge-resection of ovarian tissue is the treatment of choice when a correct diagnosis has been made.

Table III

FINDINGS ON REMOVED OVARIAN TISSUE

Gross and Microscopic Findings	*Case Number with Occurrence*							
	1	2	3	4	5	6	7	8
Fibrous thickening of ovarian cortex.	pos.	pos.	pos.	pos.	pos.	pos.	pos.	pos.
Multiple cortical follicular cysts.	pos.	pos.	pos.	pos.	pos.	pos.	pos.	pos.
Corpora albicans without blood pigment.	pos.	pos.	pos.	pos.	neg.	pos.	neg.	pos.
Atretic follicles corpus fibrosum.	pos.	pos.	pos.	pos.	pos.	pos.	pos.	neg.
Theca-lutein hyperplasia	pos.	neg.	pos.	pos.	pos.	pos.	pos.	pos.
Binucleated Primordial follicles.	neg.	neg.	neg.	pos.	neg.	neg.	neg.	neg.
Corpora Lutea	neg.	neg.	neg.	neg.	neg.	neg.	neg.	neg.
Corpora albicans with blood pigment.	neg.	neg.	neg.	neg.	neg.	neg.	neg.	neg.

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Drug Taking For Pleasure

Henry Brill, M.D., recently told the Subcommittee on Education of the U.S. House of Representatives that, "In the course of the AMA's work in this field, we have been profoundly impressed by the prime importance of public education about narcotic, depressant, and stimulant drugs. Public information has a decisive impact on public attitudes and opinions; and in the long run this determines policy. If drug taking for pleasure should ever become socially acceptable in this country and accepted as a harmless pastime, one could confidently predict that control of drug dependence would become impossible."

In this brief paper, Dr. Palmer discusses the little recognized erosive subacute esophagitis. Though often unrecognized, it is by no means uncommon.

Inflammatory Diseases Of The Esophagus*

Eddy D. Palmer, M.D./Montclair

As with all mucosa-lined organs, the esophagus falls heir to a number of acute and chronic inflammatory diseases. Most types that are of specific infectious nature are well understood pathologically and are managed with confidence clinically, due to familiarity with them in other regions of the body. Thus, no interpretational problems arise when the diagnosis is tuberculosis of the esophagus, esophageal thrush, or streptococcal phlegmonous esophagitis. Certain noninfectious forms of esophagitis, too, are well understood as soon as the diagnosis is established, such as postirradiation esophagitis and sarcoidosis of the esophagus.

It is the subacute or recurrent idiopathic form of esophagitis that has caused all the interpretational mischief. This disease is properly considered the most common abnormality of the esophagus. It has sometimes been labeled "peptic", "regurgitant" or "reflux" esophagitis, but these terms imply established etiology where no etiology is known. There are two pathologic features of special clinical importance: periodic crops of erosions, leading to hemorrhage and a subacute or recurrent nature, leading in some cases to heavy subepithelial fibrosis and stricture. The term "subacute erosive esophagitis" seems appropriate and accurate for this disease.

The esophagologist should never be surprised to encounter subacute erosive esophagitis, whatever the clinical situation might be. It is not a rare finding in the patient with pernicious anemia and the patient who has had an "antipeptic" gastrectomy. Thus, it is necessary to discard the commonly held theory that corrosion from refluxing acid-pepsin fluid is responsible for this form of esophagitis. Apparently the disease becomes especially common during pregnancy, although esophagoscopic data are sparse for the pregnant woman. Certainly subacute erosive esophagitis is particularly common in patients with direct hiatus hernia — 201 patients with esophagitis among 877 with hiatus hernia in local experience. The explanation for this association remains cryptic.

Diagnosis of this form of esophagitis is not as easy as once thought. Figures formerly taught about incidence were considerably below the correct ones. Roentgen technics are wholly impotent for demonstration of nonstricturing subacute erosive esophagitis. It was thought, on the other hand, that esophagoscopic inspection regularly gives a reliable decision regarding presence or absence of esophagitis.

A rather large proportion of cases of subacute erosive esophagitis cannot be diagnosed from surface appearances but require for recognition histopathologic scrutiny of the tissue deep to the esophageal mucosa. Without routine transesophagoscopic biopsy of the normal appearing esophageal mucosa, probably about one-third of all cases of esophagitis encountered in the endoscopy clinic would be overlooked.

This is an important revelation, not only as it

* Read before the Joint Session on Gastroenterology, Proctology and General Practice, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1969.

affects diagnosis but also because it points to a matter that must be taken into consideration in formulating a theory of etiology. Histopathologic study shows that the inflammatory process regularly begins in a deep intramural position, either the submucosa or the muscularis propria. A mixture of acute and chronic inflammatory infiltrate is found, usually spreading diffusely through the tissues but sometimes accumulated in streaks or masses through the submucosa tissues. At certain stages in the disease, in response to unknown stimuli, the inflammatory exudate extends upward toward the esophageal lumen, into and through the epithelial layer toward the surface. The result often is development of multiple erosions over the mucosal surface. The erosions necessarily cut across many rete pegs, breaching a great many capillaries.

The result is hemorrhage. In some cases the bleeding is sudden in onset and torrential in severity. The patient may quickly exsanguinate. Among 101 personal cases of bleeding esophagitis, the average blood replacement requirement per bleed was 2940 milliliters — six units on an average for each bleed! In comparison, the duodenal ulcer bleeds during the same period required only 2260 milliliters on an average per bleed. The mortality rate for bleeding esophagitis was 3 per cent.

Ice water lavage of the stomach has proved remarkably effective for emergency management of bleeding esophagitis. No other manipulation is so useful. If the bleeding should be so severe that some emergent surgical move must be made, there is no applicable approach other than segmental esophagectomy. This procedure is dangerous and not very effective.

The other important complication, cicatricial obstruction, develops in approximately 10 per cent of recognized cases of subacute erosive esophagitis. Esophagitis is regularly most severe distally, even though it may involve the entire esophagus to some extent, so it seems natural that most of the complicating strictures develop at the distal end. Ordinarily there is only one stricture, although it may be several centimeters long. The complication ordinarily comes to the patient's attention because of dysphagia. The esophageal lumen may become narrowed to a diameter of only five millimeters before the patient becomes aware of swallowing troubles. Although the resulting dysphagia is usually progressive, the progression may be very slow. The diagnosis is established by contrast fluoroscopy and esophagoscopy. Because infiltrating carcinoma may closely simulate benign stricture, it is necessary to take multiple biopsy specimens from the narrow segment at the time of esophagoscopy. Treatment is a matter of serial peroral dilations, conscientiously carried out. The experienced esophagologist can anticipate excellent results, provided the patient returns regularly for evaluation and further dilations, as required.

An important question concerns the symptomatic potentials of uncomplicated subacute erosive esophagitis. In personal experience with 237 patients with esophagitis but without hiatus hernia it was concluded that symptoms ascribable to the esophagitis had been responsible for bringing only about one-quarter of the cases to medical attention. In this small proportion of cases the bona fide esophagitis symptoms were chronic subxiphoid pain, substernal burning, and dysphagia. The rest of the cases were discovered by chance among patients who were being studied for other reasons.

Summary

Idiopathic or subacute erosive esophagitis is an intramural inflammatory disease with two important pathologic tendencies, inflammatory invasion of the epithelium with formation of erosions, and fibroplasia with development of strictures. This common esophageal disease often exists without symptomatic repercussions. But the two complications, homorrhage and stricture, may be extremely serious and are by no means rare.

143 Eagle Rock Way

In a community hospital a coronary care unit can save lives — and here is evidence.

A Coronary Care Unit In The Community Hospital*

Part II—Evaluation of Arrhythmias and Mortality following Acute Myocardial Infarction

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Harvey E. Nussbaum, M.D./Newark

The organization and operation of the coronary care unit of the St. Barnabas Medical Center was described in Part I of this report.[1] Part II of this paper deals with an evaluation of the arrhythmias and cardiac complications that occurred in the CCU during its first year of operation. In our first year, 308 patients were admitted to the coronary care unit. Ninety-two of these (30 per cent) had documented myocardial infarction according to the criteria listed below. The over-all mortality rate was 14 per cent, representing a substantial reduction from the previous year when the mortality rate was 34 per cent (without a coronary care unit). Criteria for selecting cases of myocardial infarction were:

1. History of typical long standing substernal pain.

2. Sequential electrocardiographic changes including ST segment and Q waves.

3. Sequential serum enzyme changes. SGOT-glutamic oxalocetic transaminase and LDH-lactic dehydrogenase.

4. In the absence of history, the diagnosis was acceptable only if typical sequential electrocardiographic changes occurred.

5. A typical history with changes in only ST segment and T waves with sequential elevation of SGOT and/or LDH.

6. Absence of preceding five criteria but positive autopsy evidence of myocardial infarction.

There were only 92 cases of documented acute myocardial infarction because the coronary care unit was organized with the concept of admitting every patient who was *thought* to have had an acute myocardial infarction. The remaining 216 were admitted to the unit because of chest pain or acute cardiopulmonary symptoms. There were many patients with angina pectoris and coronary insufficiency with progressive or acute inversion of T waves without enzyme changes who clinically had to be treated as "possible" coronary thromboses with or without infarction. These, however, were not included in our series because they did not meet the criteria set down at the outset of this project. There were 216 patients with a variety of diagnoses with histories and physical-findings that warranted admission to the coronary care unit. In this group the most common diagnosis (130 patients) was acute coronary insufficiency with angina pectoris. All of these patients were monitored and followed as carefully as those with acute myocardial infarction. There were no fatalities in the non-infarction group in the coronary care unit. This was achieved by means of specially trained cardiac nurses, also through constant electrocardiographic monitoring, daily serial electrocardiograms and by examining monitor electrocardiographic strips every hour or whenever needed. The comprehension of the arrhythmias and the treatment of these patients were enhanced by the services offered in the coronary care unit. This experience has emphasized to us the need for an additional "concentrated cardiac area," separated from the acute coronary care unit but close enough to it so that the same medical and nursing personnel would be available for these patients.

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The largest number of infarctions occurred in the 51 to 60 year old age group. Males predominated by a ratio of 2½ to 1. The overall ratio of male to female was 72 to 20, or 3½ to 1. The combined age from 51 to 70 made up 63 per cent of the entire group. The youngest age group of infarctions was from 31 to 40, with three male patients. In the oldest age group, 71 to 80, there were 16 patients with a 2 to 1 ratio of male to female. The greatest number of deaths (five of them) occurred in the 61 to 70 year old age group.

The highest proportion of deaths occurred in the youngest age group (31 to 40) where there was one death out of three cases, a 33 per cent mortality. In view of the small number of cases in this age group, this statistic is not reliable. Of the total 13 deaths, nine occurred in the age group 51 to 70.

The electrocardiographic changes localized 45 per cent of the infarctions in the anterior wall, and 38 per cent in the posterior wall. And 13 per cent were in the subendocardial area (4 posterior, 9 anterior). The figure was one per cent each in the posteriolateral and antero-septal-inferolateral area.

The SGOT was elevated in 87 per cent of the infarctions. In no case in the subendocardial infarction group was the SGOT elevated.

Of the 92 patients with acute myocardial infarction admitted to the coronary care area, 72 had some form of arrhythmia. The presence of arrhythmias in acute myocardial infarction varied considerably with the reports from many coronary care units.[2 to 9] This inconsistency must be due to varying accuracy in the reporting of arrhythmias. It depends upon several factors:

1. The ability to recognize arrhythmias and the degree of effort and interest expended by the nursing staff in the coronary care unit.

2. If the monitoring equipment has an oscilloscope which produces only one electrocardiographic pattern at a time, many arrhythmias will be missed on the other patients who are not seen on the oscilloscope at that particular time. This was why some of the arrhythmias we recorded appeared to be less frequent than reported in other groups. This emphasizes the need for a large oscilloscopic screen to view at least four patients simultaneously. Those arrhythmias that would set off the alarm signals, such as ventricular tachycardia, ventricular fibrillation and ventricular standstill are much more likely to be accurately recorded by the nursing staff than the occasional PVC's, low grade AV block and arrhythmias that would not set off the alarm system.

Arrhythmias—Incidence and Treatment

Ventricular Ectopic Mechanisms

The most common arrhythmia in this group was the premature ventricular contraction,[3] occurring in half of all the arrhythmias. Recurrent premature ventricular contraction may be a precursor to ventricular tachycardia, and fibrillation. It is, therefore, important that it be recognized by the cardiac-nursing staff. Should the PVC's occur at a frequency of greater than five per minute, in groups of two or more, or have a multiform pattern, the coronary care nurse has the authority to immediately administer 50 milligrams of lidocaine (2 per cent xylocaine) intravenously and repeat 50 to 100 milligrams if the arrhythmia persists. If the ectopic beats were suppressed, then an intravenous drip was maintained at the rate of one to two milligrams of lidocaine per minute, or a sufficient amount to prevent the recurrence of the arrhythmia. If the lidocaine proved to be ineffective then procainamide 100 to 200 milligrams (Pronestyl®) was used by intramuscular injection, or by intravenous titration with a dosage of 1 to 2 Grams in 250 to 500 cc. of 5 per cent glucose and water.

Ventricular tachycardia occurred in 18 per cent of the arrhythmias. The sudden appearance of ventricular tachycardia was immediately treated with a large intravenous dose of lidocaine (xylocaine 2 per cent) 50 to 100 milligrams repeated in a few minutes if there was no response. Following regular sinus rhythm the patient was maintained on continuous intravenous lidocaine at sufficient speed to prevent recurrence. Should the patient show any signs of congestive failure or shock, cardioversion was performed immediately. After regular sinus rhythm was restored by cardioversion quinidine 200 to 400 milligrams, was given every six hours to prevent recurrence of ventricular tachycardia. Persistent ventricu-

lar tachycardia occurred often without any undue clinical manifestations. Often, the patient was aware only of palpitation. If there was no response to lidocaine, electrical cardioversion was carried out after giving the patient intravenous Valium® 10 to 25 milligrams slowly. We had seven cases of non-paroxysmal (idioventricular) ventricular tachycardia. This arrhythmia occurred in five patients with anterior infarction and in two patients with posterior infarction.

It is very likely this arrhythmia occurred more frequently than we were able to detect because the patients do not show any clinical manifestations of the abnormal rhythm. The NPVT's are considered a benign and short lived arrhythmia and do not require any specific treatment.†

Our ten cases of ventricular fibrillation had a mortality of 50 per cent. To evaluate the incidence of ventricular fibrillation it is important to classify this arrhythmia in its proper clinical setting. Most patients will present terminal or agonal ventricular fibrillation following intractible congestive heart failure and/or shock. On the other hand sudden ventricular fibrillation may occur in early acute myocardial infarction in the wake of a normal sinus rhythm. By following the classification of ventricular fibrillation as proposed by Oliver *et al.*,[10] a much clearer understanding of its pathogenesis, treatment response and statistical occurrence will be achieved. The classification is as follows:

1. *Primary ventricular fibrillation.* In the patient without cardiac failure and/or hypotension (systolic blood pressure less than 100 millimeters of mercury).

2. *Complicating ventricular fibrillation.* Complicating, pre-existing cardiac failure and/or hypotension in patients not in a terminal state.

3. *Agonal ventricular fibrillation.* In patients who before the development of ventricular fibrillation have already lost a vital function, such as blood pressure or respiration.

4. *Pacemaker-induced ventricular fibrillation.*

5. *Drug-induced ventricular fibrillation.*

The ten patients with ventricular fibrillation in this study were classified as follows: two cases of "complicating ventricular fibrillation," three of "agonal ventricular fibrillation" and five of "primary ventricular fibrillation." All five survivors were of the primary group. Ventricular fibrillation in this group occurred in a matter of hours after the onset of their symptoms. The patients with acute myocardial infarction of the primary ventricular fibrillation group usually responded very well to electrical defibrillation by reverting to regular sinus rhythm. The large majority of these patients had not had any recurrence of the ventricular fibrillation. Those patients however who developed ventricular fibrillation several days after the myocardial infarction with pre-existing cardiac failure and/or hypotension did not respond as well to defibrillation. The earlier the ventricular fibrillation occurs in the course of the acute myocardial infarction the more likely it is to respond to successful defibrillation. The patient with myocardial infarction who is admitted to a coronary care unit 12 to 24 hours after the onset of his symptoms is less likely to show arrhythmia of ventricular fibrillation than the patients admitted earlier.

Sino-Atrial Mechanisms

Sinus tachycardia by itself was not treated since it was considered a pathophysiologic adaptation to the cardiac insult, in an effort to maintain cardiac output. If it occurred with myocardial failure then the patient was digitalized with either intravenous ouabain or Cedilanid.® If rapid action is desired ouabain is the drug of choice. The onset of action is in 3 to 10 minutes, with maximum effect in 30 minutes to 2 hours. It is excreted in 24 hours. A full digitalizing dose of ouabain is 1 milligram. In urgent cases the milligram may be given in three divided doses in one hour. In less urgent cases 0.2 milligram is given every 30 minutes and repeated at these intervals as needed. When haste is not necessary, ouabain is an excellent drug with which to observe the effects of a rapid acting digitalization particularly in patients when previous digitalis therapy is questionable. In these cases 0.1

† Since the preparation of this paper we have had one patient with NPVT who suddenly developed cardiac arrest manifesting ventricular fibrillation. The patient was immediately defibrillated and made a complete recovery.

milligram of ouabain is given intravenously every 4 hours. After digitalization is achieved with intravenous ouabain then a longer acting maintenance dose of a glycoside, such as digoxin, should be given.

Atrial fibrillation or atrial flutter occurred in 13 per cent of the cases and was not a serious problem. The treatment of choice was digitalization with intravenous Cedilanid® or ouabain and once a regular sinus rhythm was restored. maintenance was by way of quinidine 200 to 300 milligrams given three times daily. If atrial flutter could not be reverted and persisted more than one hour, cardioversion was used. If the rapid ventricular rate of atrial fibrillation could not be slowed by intravenous Cedilanid,® or ouabain, cardioversion was employed and the patient maintained on oral quinidine.

Premature atrial contractions occurred in 13 per cent of the patients, and premature nodal contractions and nodal tachycardia in 17 per cent. This was not a problem in management nor did it usually provoke or precede any detrimental arrhythmias. These arrhythmias must obviously be treated as any supra-ventricular tachycardia. Carotid sinus pressure may be used but with extreme caution in patients with an acute myocardial infarction. If digitalis was used, it should be stopped because this arrhythmia is so often a manifestation of digitalis toxicity. If there is any deterioration of vital signs, especially hypotension, Levophed® or Aramine® should be administered. If these measures are ineffective (and if one is certain that the tachycardia is *not* due to digitalis and diuretics) the patient may be digitalized. The treatment of choice, however, would be to administer D. C. countershock under intravenous Valium® effect, particularly if you are sure that the arrhythmia is not due to digitalis. Countershock should also be used if this arrhythmia persists after the digitalis or diuretics are stopped for several days.

Bradycardia, Heart Block and Asystole

Sinus bradycardia[11] occurred in 14 per cent of the total cases and (as expected) in two thirds of the cases of posterior wall infarction. Sinus bradycardia was not a significant problem in acute myocardial infarction, so long as the sinus node remained the sole pacemaker, and congestive heart failure or ventricular premature contractions or ventricular fibrillation did not occur. A rate as slow as 50 per minute could be tolerated by the patient without any alarm. However, should congestive heart failure, premature ventricular contractions or ventricular tachycardia occur, then treatment would be indicated without delay. Intravenous atropine in doses of 0.3 to 1.2 milligrams (repeated in several minutes if necessary) should be given. If this does not speed up the sinus rhythm then a continuous drip of isoproterenol 1 milligram in 500 cc. glucose and water is started and titrated at the proper speed to increase the sinus rhythm to 70 beats per minute. This should eliminate the premature ventricular contractions, improve cardiac output and help to alleviate the congestive heart failure. If the heart rate does not speed up to 65 or 70 beats per minute in the face of congestive heart failure and premature ven tricular contraction then a transvenous pacemaker should be introduced. In the presence of a bradycardia whether due to a slow sinus mechanism or to heart block with complicating arrhythmias such as premature ventricular contractions or ventricular tachycardia, it is important not to give antiarrhythmic agents which would further aggravate the bradycardia and knock out the ventricular pacemaker.

Atrio-ventricular block (including first, second or third degree) occurred in 27 per cent of the cases; most of them with inferior wall infarction. First degree AV block did not require any special treatment but alerted the nursing staff to be on the watch for the development of any further high grade block. In the presence of second and third degree AV block (13 per cent of cases), atropine and isoproterenol were administered as described above for the complications of bradycardia. As soon as second degree heart block was recognized the patient was given 0.5 to 1 milligram atropine intravenously and repeated if the block was not eradicated. If this failed, isoproterenol one milligram in 500 cc. glucose and

water was given by continuous intravenous drip at a rate sufficient to break the block. If isoproterenol therapy was unsuccessful, then a transvenous pacemaker was introduced. In the event of a 2 to 1 block, Wenckebach, complete heart block and sudden runs of asystole, these measures were immediately instituted prior to introduction of a pacemaker.

Pacing several hours a day in most cases was sufficient to maintain cardiac compensation with an adequate cardiac output. When the pacemaker was turned off, the patient's own pacemaker (sinus node) took over. If the patient's own pacemaker was found to be incapable of maintaining proper sinus conduction, then the electrical pacemaker was again started. The longest pacing required in this group was 72 consecutive hours. In most of these patients however the pacemaker was shut off after a few hours, but left in place for 12 days to insure against recurrence of the AV block.

Fifteen patients required pacemakers (*via* superficial or deep jugular)** because of second or third degree heart block, sudden asystole, AV dissociation or a combination of AV block and bundle branch block. Thirteen of these patients survived and left the hospital in satisfactory condition. The deaths of two of these patients was not related to the need for pacing; both achieved regular sinus rhythm after pacing. Ten of these patients required continuous pacing for 1, 2 or 3 days, after which their own sinus pacemaker functioned satisfactorily. At the time of discharge from the hospital, *all* of these patients were in regular sinus rhythm. Only two had a PR interval consistent with a first degree AV block. One patient had an extensive anterior and posterior wall infarction with congestive heart failure and shock. He recovered slowly from his myocardial failure and shock but developed cardiac arrest (ventricular asystole), followed by the first and second degree AV block. A temporary pacemaker was introduced and he was paced intermittently for five days following which his own pacemaker took over satisfactorily. The pacemaker catheter was left in place for an additional 10 days after his own sinus rhythm was effective.

Causes of Death

1. A patient, who lived six hours, had an acute anterolateral wall infarction and showed congestive heart failure on admission and became progressively worse. Electrocardiogram showed descent of the pacemaker to final ventricular fibrillation and death.

2. One man, who died on the fourth day, had an acute anteroseptal myocardial infarction with congestive heart failure which did not respond to any measures. He developed a loud friction rub and a systolic murmur and diastolic murmur on the second day which persisted to death. Autopsy was not obtained but it was thought he may have had a ruptured septum.

3. A patient died on the tenth day after a sudden episode of pulmonary edema while on the "concentrated" medical floor. He was in the coronary care unit for five days prior to his transfer to the concentrated care area. He was returned to the coronary care unit on the tenth day, where he died.

4. One, who died on the eleventh day, had been in the coronary care unit the entire time because of a tracheostomy for severe respiratory distress. He also had a temporary pacemaker, which converted his heart block to regular sinus rhythm. Autopsy revealed an acute posterior wall infarction involving the inferior portion of the ventricular septum and inferior portion of the atrial septum. There was a pulmonary embolus with involvement of the left lower lobe. He had the highest SGOT we have seen: over 6000 units on the second day.

5. One patient died of sudden cardiac arrest on the fifth day in the coronary care unit. The arrhythmia was not observed on the monitor oscilloscope or electrocardiograph, so the exact pathogenesis of the arrest is not known.

6. One man died of a sudden cardiac arrest on the 15th day. He was in the coronary care unit for six days and improved sufficiently to be transferred to the concentrated medical floor. The sudden arrest occurred while in bed. He was attended by the emergency resuscitation unit. The arrest was ventricular fibrillation, but did not respond to electrical defibrillation and other supportive measures.

Three patients died from acute cardiogenic shock with myocardial infarction. They lived 4½, 11 and 36 hours respectively. One lived 4½ hours in the coronary care unit. He developed ventricular fibrillation two hours after admission to the unit.

7. One male patient lived 11 hours in the coronary care unit. The patient was seen within two hours of the onset of symptoms. Electrocardiogram showed an acute anterolateral wall infarction. The monitor showed left bundle branch block, sinus tachycardia, premature nodal contractions and premature ventricular contractions.

** The direct percutaneous subclavicular transvenous technic was started after this group of patients.

8. Another survived for 36 hours in the coronary care unit. The electrocardiogram showed left bundle branch block. On the monitor the patient showed premature ventricular contractions, then developed ventricular fibrillation two hours after admission to the unit.

9. A man was admitted with congestive heart failure and shock and lived 29 hours in the CCU. Two weeks prior to this admission he had been in another hospital for two days. Autopsy revealed an acute anteroseptal infarction, congestive heart failure and mural thrombosis. The left ventricle showed evidence of recent and old myocardial infarction.

10. One woman was in the coronary care unit for nine days, then transferred to the concentrated medical floor. The patient was returned to the coronary care unit on the 17th day because of sudden chest pain thought to be due to a pulmonary infarction. She died on the 20th day and autopsy permission was not obtained.

11. One patient was in the coronary care unit for 14 days, then transferred to the concentrated medical floor. This patient had an AV block and congestive heart failure. A pacemaker was introduced on the fourth day and remained in the right ventricle until the 11th day. The patient had a regular sinus rhythm after pacing intermittently for three days. On the 15th day the patient was transferred to the concentrated medical floor. Sudden death occurred on the 30th day while sitting in a chair. Autopsy permission was not obtained.

Our Coronary Care Unit (CCU) was effective in reducing the mortality rate from 34 to 14 per cent during its first year of operation. This was achieved primarily by the recognition and treatment of the pre-fatal arrhythmias: premature ventricular contractions, ventricular tachycardia, ventricular fibrillation and high grade atrioventricular block. The tachyarrhythmias were controlled with the anti-arrhythmic agents lidocaine, procainamide, diphenylhydantoin (Dilantin®), quinidine and propranalol, or countershock. The varying degrees of AV block were treated with atropine, isoproterenol, and the bipolar catheter pacemaker.

Treatment of heart failure in the patient with an acute myocardial infarction is not so clearly defined as management of the arrhythmias. One of the first clinical signs of failure of the ischemic heart are the appearance of the third and fourth heart sounds accompanied by accentuation of the pulmonic component of the second heart sound. These findings are due to failure of the left ventricle to maintain a normal end-diastolic pressure, as manifested by elevation of the pulmonary artery and right ventricular pressure (end-diastolic pressure). During careful auscultation of these patients, one can often hear a triple or quadruple rhythm (gallop). It is also not uncommon to hear fine basilar rales with or without this type of gallop rhythm. The patient, however, may appear quite comfortable and does not show the clinical signs classically associated with advanced congestive heart failure, namely dyspnea, generalized venous hypertension, pulmonary congestion and edema. Soloff[13] pointed out that these patients do not have classical congestive heart failure and states clearly that any type of failure — clinical, biophysical, biochemical, molecular — may be present in the absence of congestive heart failure. Clinically this is aggravated by intramyocardial factors such as valvular dysfunction, arrhythmias, drug toxicity, hypoxia, acid-base imbalance, physical activity and the ingestion of salt.

It may well be that all patients with acute myocardial infarction have some degree of subclinical failure, and may not require any specific medication. The patient, however, with the earlier signs of left ventricular failure, manifested by a gallop rhythm and scattered basilar rales may respond well to any of the potent diuretic agents, as long as the electrolytes are in balance.

The challenging problem with the acute myocardial infarction patient is when to use digitalis and how much. Some cardiologists would digitalize even the above subclinical types. At present, we do not ascribe to this regimen. Digitalis should be started if rales are persistent after adequate diuretic therapy. Half to two-thirds of the normal digitalizing dose should be adequate. Isoproterenol in small doses may be tried in place of digitalis. Its inotropic effect may achieve the needed improvement in myocardial contractility without the use of digitalis and thus remove the threat of digitalis toxicity. It must be remembered that the infarcted myocardium is extremely sensitive to digitalis, and toxicity is rapidly achieved with its disturbing arrhythmias. The patient with advanced congestive heart failure, however, should be treated immediately with digitalis, the intravenous route prefer-

ably, using Cedilanid® or ouabain starting with small doses and building up as necessary.

Early recognition of atrio-ventricular block in the presence of myocardial infarction is essential for effective treatment. Increasing degrees of high grade AV block calls for immediate introduction of a transvenous pacemaker to prevent ventricular tachycardia, ventricular fibrillation and/or ventricular standstill. There is some disagreement about the exact degree of AV block at which one should introduce the catheter pacemaker. There are also other vital arrhythmias and conduction aberrations (in the presence of myocardial infarction) that should be paced. It is recommended that transvenous catheter pacing (bipolar) be instituted for the following conditions:

1. (a) Sinus bradycardia (rate less than 50) with premature ventricular contractions occurring at least five per minute; and

(b) Sinus bradycardia with congestive heart failure.

2. Second degree or third degree AV block.

3. Sinus bradycardia less than 40 beats per minute.

4. Sinus arrest.

5. Complete right bundle branch block with left axis deviation.

6. Combined left bundle branch block with first degree AV block.

7. Intermittent SA block or Mobitz II block.

Patients with posterior wall infarctions (right coronary artery occlusion) have AV conduction abnormalities more often than anterior wall infarctions. We have observed two patients with first degree AV block during the first five days of illness in the coronary care unit with prolongation of the PR interval to 0.28 seconds without any other complications. Five to ten days later after transfer to the medical floor they suddenly developed a high grade atrioventricular block which progressed to a 2 to 1, 3 to 1, complete heart block, and ventricular tachycardia and asystole. This development of high grade block from first degree AV block was unpredictable. Most of the patients with high grade AV block who were paced for several days had complete return of regular sinus rhythm conduction. It is important in these patients to leave the catheter in place for 10 to 12 days, because the AV block may recur. This is especially so in complete heart block.

Results from our unit and experience of others indicate that ventricular fibrillation can be treated with about 50 per cent recovery. Lown, *et al.*[9], reported total prevention of ventricular fibrillation in their series. This was a remarkable achievement but may

Routine Coronary Care Orders

1. Notify Cardiac Fellow *on duty* of every admission.
2. EKG — STAT. Then attach the patient to monitor with needle electrodes. (Shave chest of male patients in 4" area around needle sites).
3. SMA-12, CBC, Elect.
4. SGOT, SGPT, LDH, CPK, three consecutive days.
5. Portable X-Ray chest within 24 hours.
6. Daily EKG.
7. Intake and output.
8. Oxygen via nasal cannula, 6-8 liters per minute.
9. If ventricular premature contractions occur more frequently than 5 per minute, occur in groups, are multifocal, or occur at apex of T waves, give Lidocaine (Xylocaine) 50 MG. intravenously (Bolus) immediately and repeat in 1 minute, if necessary. If heart block is evident, do not carry out Order #9.
10. If ventricular fibrillation occurs, defibrillate immediately at 300 Joules. If not effective, repeat at 400 Joules. Follow S.O.P. cardiac resuscitation.
11. If asystole occurs, turn external pacer on voltage to 120, rate to 75. Follow S.O.P. cardiac resuscitation.
12. Start resuscitation procedure and sound "111" for #10 and #11.
13. When #9, #10, #11, #12 occur, notify at once Attending, Cardiac Fellow, Resident and Interns.
14. Glucose and water intravenous very slowly to keep vein open.
15. Medical consultation in compliance with By-Laws.

be due to the fact that his patients are not admitted to the CCU as soon after symptoms occur as are our patients. We have documented evidence of patients with an acute anterior wall infarction in regular sinus rhythm who suddenly developed ventricular fibrillation after one premature ventricular contraction. There is no way to prevent ventricular fibrillation under such circumstances.

One of the most dramatic events in the coronary care unit is the conversion of cardiac arrest to a normally functioning heart rhythm and eventual discharge of the patient from the hospital. Indeed successful cardiac resuscitation is a very important achievement, but it is not the real function of a coronary care unit. The basic function and productivity of the coronary care unit is the recognition and prompt treatment of the pre-fatal arrhythmias and correction of conduction defects.

Summary

1. The first year of operation of a Coronary Care Unit in a community hospital reduced the mortality rate of acute myocardial infarction from 34 to 14 per cent.

2. The effectiveness of a CCU is based upon the ability of the specialist cardiac nursing staff to recognize pre-fatal arrhythmias; and in giving these nurses the authority to immediately administer the indicated medication and to use defibrillation when needed. (See CCU standing orders for new admissions).

3. The prevalence of the most common arrhythmias with acute myocardial infarction were reported, and their treatment discussed.

4. There were 13 deaths, 8 died in the CCU, 5 in the wards. Five deaths were due to congestive heart failure, three due to shock and one to rupture of the myocardium. There were two "sudden deaths" (causes unknown), and two due to sudden cardiac arrest.

Six detailed tabulations and a bibliography appear in the authors' reprints.

109 South Munn Ave. (Dr. Leff)

Medical Assistants Offered Loans

Any qualified young person wishing to pursue a career as a medical assistant may apply for a scholarship loan through the Maxine Williams Scholarship Fund, sponsored by the American Association of Medical Assistants' Endowment.

Participants in the loan program may borrow up to $300 for their education. As a service to the profession, AAMA assumes all administrative costs so there is no interest rate on the loan. If the recipient spends a minimum of two years in the medical assisting field, the loan becomes an outright scholarship, and no repayment is required.

The fund, named in honor of Miss Maxine Williams, AAMA's first president, is supported entirely by private donations from state medical assistant associations as well as local chapters. Contributions are tax deductible as an educational expense.

To be eligible for a loan, one must be a high school graduate who wishes to take formal training in medical assisting. At the present time, AAMA is working with the American Medical Association on an approval program, eventually leading to a standard medical assisting curriculum. The suggested two-year program recommends both administrative and clinical training for an Associate Arts degree at an accredited community or junior college.

Application blanks and information about the Scholarship Loan Fund may be obtained from American Association of Medical Assistants, 200 East Ohio Street, Chicago, Illinois 60611.

Indications for surgery in regional enterocolitis are here clearly spelled out in their brief monograph.

Regional Enterocolitis*

Eugene P. Salvati, M.D./Plainfield

Crohn[1] and his associates first described regional enteritis in 1932 but it was not until 1951 that Rappeport[2] reported colonic involvement in 55 of 100 cases of regional enteritis. In recent years many other reports have appeared, notably that by Janowitz.[3] In 1965 he reviewed sixty cases of regional colitis and Bacon,[4] a similar number, in 1966. Thus, involvement of the colon in combination with (or separate from) the small bowel by a disease process is recognized as a distinct clinical entity. This can be differentiated from ulcerative colitis in most cases both clinically and pathologically. As more surgeons review their experiences, they find that disorders formerly labeled ulcerative colitis were actually regional colitis.

This is a statistical review of 17 cases of regional enteritis, ileocolitis, and regional colitis personally operated upon over the past 10 years. The most common symptoms were abdominal cramps and weight loss associated with moderate diarrhea. Anemia was found in every case although rectal bleeding was not a prominent feature. Anal fistulae were present in 58 per cent of the cases and preceded the diagnosis of the disease in every instance. Sigmoidoscopy was normal in 12 cases; in two, isolated rectal ulcers were noted and in three, proctitis was present, indistinguishable from ulcerative colitis.

In nine cases, the ileum only was involved; in two, the colon and in six, the ileum plus the colon. Grossly, the bowel wall was markedly thickened. Usually, enlarged lymph nodes were present. Longitudinal ulcerations of the mucosa were characteristically noted and microscopically the muscle layer was markedly thickened and all layers of the bowel were infiltrated with plasma cells, lymphocytes and eosinophils. In eleven cases (64 per cent) a granulomatous or sarcoid reaction was found.

Age of onset ranged from 5 to age 38. Two occurred in the first decade; five in the second; three in the third; and seven in the fourth. Three patients did not receive any prior medical treatment. Five patients received Azulfidine.® Nine patients were given both Azulfidine® and steroids prior to surgery.

TABLE I

Indications for Surgery
17 Patients
29 Operations

Obstruction	16
Internal Fistulization	7
Intractable Disease	4
Unhealed Anal Wound	1
Proctitis	1

Indications for surgery were as follows: obstruction in 16 cases or 57 per cent; internal fistulization in 7 cases or 20 per cent; intractable disease in four cases or 14 per cent. The remaining two patients were operated upon for an unhealed anal wound and proctitis.

Twenty-nine operations were done. Four had a partial ileectomy; one a partial duodenectomy; 14 patients underwent ileectomy and right hemicolectomy. Three had a subtotal

TABLE II

Type of Surgery
17 Patients = 29 Operations

Duodenectomy	1
Partial Ileectomy	4
Ileectomy and Right Colectomy	14
Subtotal Colectomy and Ileorectostomy	3
Total Colectomy and Ileostomy	2
Left Colectomy and Ileorectostomy	3
Sigmoidectomy	1
Proctectomy	1

* Read before the Sections on Gastroenterology and Proctology, and General Practice, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969.

colectomy and ileorectostomy; two a total colectomy and ileostomy; three a left hemicolectomy and ileorectostomy. One sigmoidectomy and one proctectomy were also done.

Ten patients had one operation and these are all living and *well* with no recurrence. Four patients had two operations each. Two of these have developed recurrences and at present are *controlled with* Prednisolone.® One patient has had three operations and is now well. Two patients had four operations and are now well. The recurrence rate was 41 per cent. There were no deaths. There were no cases of carcinoma, toxic dilatation, or free perforation.

TABLE III

10 Patients had 1 Operation
No Recurrence
4 Patients had 2 Operations
2 Recurrences
1 Patient had 3 Operations
No Further Recurrence
Recurrence Rate — 41 per cent
No Deaths

Fistulectomies were done on eight patients with this problem. In three, the wound healed despite the subsequent diagnosis of enteritis or colitis. Two patients required definitive bowel surgery before the wound would heal. Three had a fistulectomy after bowel surgery. One patient required proctectomy and colectomy and one (with recurrent disease) still has his fistula and will probably require proctectomy.

One patient in this series had a total colectomy and proctectomy for ulcerative colitis. The diagnosis was confirmed by review of the gross and microscopic findings. He then developed a typical regional ileitis with obstruction necessitating removal of all the small bowel except the proximal 54 inches. Later a reversal of a jejunal segment was done. Three years have passed since then, and he is doing quite well. This makes one wonder whether the development of regional ileitis was coincidental or whether there is more than a casual relationship between regional ileitis and ulcerative colitis.

Comment

Surgery for regional enteritis, ileocolitis or regional colitis should be confined to treating the complications of this disease such as obstruction, internal fistulization and those unresponsive to medical therapy. A reasonable response can be expected from surgery but the recurrence rate is high and repeated resections are frequently needed. A fistula in the first three decades of life *should* make one suspicious of enteritis and this diagnosis should be ruled out prior to fistulectomy. One can not say for certain what is the proper operative procedure for regional colitis. Probably subtotal colectomy and ileorectostomy are indicated for patients with more than ascending colon disease. The prognosis appears to be better when the primary involvement is in the colon.

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1010 Park Avenue

204th ANNUAL MEETING

May 16-19, 1970 Atlantic City

If we physicians don't interest ourselves in the emotional illnesses of adolescents and children, other groups will be glad to relieve us of that job.

Physicians' Involvement In Emotional Disorders Of The Young

Eugene V. Resnick, M.D./Paramus*

Soon after its formation, the Special Committee (of The Medical Society of New Jersey) on Emotional Disorders of Childhood and Adolescence decided that one of its first efforts should be an attempt to survey the manner in which the diagnosis, treatment, and prophylaxis of mental and emotional illness in children and adolescents was being dealt with throughout the state and the degree of interest and involvement of physicians and our 21 county medical societies. Accordingly, on January 26, 1968 the following letter was sent to the secretary of each county medical society in New Jersey:

The Special Committee on Emotional Disorders of Childhood and Adolescence of The Medical Society of New Jersey would like to be of service to each county medical society in its concern over provision of adequate medical facilities for the mentally and emotionally ill youngsters of your community. We are well aware that in many, if not all, areas of the state both in-patient and out-patient psychiatric facilities are either inadequate in size or scope, or non-existent. Although the medical profession alone cannot solve this problem, the Committee feels that we could play a central role in trying to remedy it—else other groups will step in to create ill-conceived and ineffective plans. At least, so history tells us!

We should like to begin this work by asking you to give us some information about your county. We are not interested especially in a *statistical* survey of your needs and facilities, although if you already do have data of this kind, we'd be pleased to receive them. What we are more interested in is a sophisticated resumé of how mentally and emotionally ill youngsters in your area are handled—and why—and what changes are called for. We have formulated a list of questions for your use as a guide in formulating your resumé. Here they are:

1. Is there concern in your county about lack of facilities? By whom?

2. Who, if anyone, is "pushing" for creation of additional facilities? Of what type?

3. What has been the role of the county medical society in "pushing" for and/or planning new facilities?

4. Do you have an active Mental Health Association? What has been its role? What is its leadership?

5. What has been the role of psychological, social work, and/or educational groups in planning and development of facilities?

6. What has been the role of the county Mental Health Board and its professional Advisory Committee? What role do physicians play in these groups?

7. Who is seeing and "treating" psychologically ill youngsters in your county

Pediatricians?
General Practitioners?
General Psychiatrists?
Child Psychiatrists?
Psychologists?
Social Workers?
Clergymen?
Educational Personel?
Other?

8. What kind of resources are available to the non-psychiatric physician of your county for referral of patients? Please comment on the adequacy (quantitatively and qualitatively) of each of the following resources (including such elements as geographical availability, waiting lists, finances, etc.):

a. In-patient facilities:

Public hospitals
General hospitals
Residential care

b. Partial hospitalization facilities (Day and/or night)

c. Out-patient facilities:

General psychiatrists in private practice
Child psychiatrists in private practice

* Dr. Resnick is Medical Director, Hackensack Community Health Service.

Psychologists
Public Clinics (government sponsored or non-profit private)
Court-affiliated clinics

d. Emergency Services

9. To whom *do* your non-psychiatric physicians refer youngsters for evaluation and for "psychotherapy".

General psychiatrists?
Child psychiatrists?
Psychologists?
Others?

10. What role do physicians have in school systems vis à vis psychologically ill youngsters? Do school personnel refer youngsters requiring private treatment to psychiatrists or to non-medical professionals (psychologists, etc.)?

11. Is there interest among non-psychiatric physicians for educational programs in child and adolescent psychiatry? What type of programs:

Lectures?
Seminars?
Hospital-based programs (in staff meetings, out-patient depts., etc.)?
Others?

12. Do you have any specific suggestions for action by The Medical Society of New Jersey's Council on Mental Health, or its Special Committee on Emotional Disorders of Childhood and Adolescence?
How may we help you?

On October 9, 1968, those county societies which had not replied to this letter were sent the following reminder:

In January 1968, the Committee on Emotional Disorders of Childhood and Adolescence sent your county medical society an inquiry on the nature, quantity and quality of mental health facilities for children and adolescents in your area. Because we have not received a reply from you, we are writing again to request this information.

Please send us whatever information you have available, no matter how meager or briefly stated, and do not feel bound to respond to the detailed questions of the original letter. We are as eager to know of your society's lack of interest in this matter as of its enthusiasm. In essence, we should like to know of both the problems and accomplishments in your area in regard to diagnosis, treatment, and prophylaxis of mental and emotional illness in children and adolescents.

In all, replies were received from ten out of our 21 county medical societies. Some of the larger societies and many of the smaller ones did not reply. Several of the larger counties from which no reply was received are known to have active mental health programs under medical auspices and substantial numbers of psychiatrists as members of the county medical society. Perhaps this unresponsiveness indicates the local medical community's lack of interest in mental health matters; or, maybe, that psychiatrists are not involved in county medical society activities; or that the groups felt that their limited time and energies might be put to more constructive use than answering "another questionnaire."

The nature of the ten replies received varied greatly. Some were sophisticated essays, giving considerable detailed information about the situation in the county. Others were brief general summaries. Still others consisted of hand-written notations on the margins and blank spaces of the original survey letter. Although the majority of the replies apparently were written by psychiatrists, there was evidence that most of them adhered to the survey's request for information that would "reflect the views and practices of all segments of the medical community."

In addition to the modest number of replies received, the content of the replies indicated a sparse and spotty medical interest and involvement in facilities for the young mentally and emotionally disturbed. Although there were several exceptions, most of our county medical societies apparently were not involved actively in the planning for (or the creation of) facilities. The leadership in this more often was in the hands of lay groups and/or non-medical professional groups. There seemed to be a general feeling of frustration and pessimism in regard to the ability of the medical profession to be effective in creating sufficient new facilities.

The survey indicated, for the most part, a paucity of existing facilities. Apparently, there are relatively few child psychiatrists practicing in the state, and these are concentrated in the more populous metropolitan areas. There seem to be more adequate numbers of general psychiatrists in private practice. Many of them, of course, do work with children and most of them with adolescents. Many children and adolescents were being "treated" by non-medical professionals, especially psychologists. Several replies indicated doubt about the quality of the work done by these non-medical professionals. Out-patient clinics were cited as being too few in number and often overburdened by the great demand for their services, which their small staffs could not handle

Some said that many clinics worked ineffectively and unproductively. Almost all the replies indicated that inpatient and partial hospitalization facilities for children and adolescents were either meager or non-existent.

School personnel showed a high degree of interest in children's emotional problems. However, this interest often was relatively unsophisticated and focused on the school's need to change the student's aggressive and unsocial behavior. One reply commented upon the increasing skill in school personnel in being able to identify emotionally ill children and the frustration these educators met in attempting to find suitable treatment facilities for the students so identified.

Generally, the replies indicated minimal interest among non-psychiatric physicians for formal educational programs in child and adolescent psychiatry, although there was some indication that physicians were interested in getting practical help in dealing with their problem patients.

Some of the replies had specific suggestions to make. These included one suggestion that The Medical Society of New Jersey disseminate information on educational programs for non-psychiatric physicians directly to the county societies. Another reply requested help from the Council on Mental Health in influencing the Department of Institutions and Agencies to be more effective in promoting mental health centers under *local* control. A third reply recommended the establishment of Walk-In-Clinics, to function as brief, rapid diagnostic centers and to provide emergency treatment "with less of the classic evaluation approach, with its tedious work-up process, its waiting and conferences." In such a clinic, "a trained psychiatrist could quickly classify those whom he or his clinic could help and those who must be administratively disposed of to a state facility, a drug program, an acute family counseling team, or other immediate and functionally effective operating channels." This respondent complained that "psychiatrists trained in child psychiatry were all devoting . . . more of their time to administrative and other clinic activities . . . but little to seeing children. Treatment, where it exists, is done largely by the ancillary or para-psychiatric discipline, under the *nominal* supervision of a psychiatrist when in a clinic setting, and without supervision when done privately."

One reply suggested that psychiatrists and other physicians might be more effective by working in and through school systems in programs of secondary and tertiary prevention, through early case finding and through intervention to help structure the school situation best to promote mental health and deal with mental illness. This kind of work would involve the physician serving primarily in a consultative role to various school personnel, both administrators and teachers, as well as doing some mainly diagnostic work with students.

The common situation relative to what kind of professional "treats" mentally sick youngsters is exemplified by the following reply: "There does not seem to be any real consensus on which type of professional should be treating which child, and the decision on this usually depends on the personal inclination of the individual or agency which sees the need for treatment. Most, but not all, of the child treatment clinics in our county have psychiatrists on their staffs, but the degree of psychiatric leadership permitted in each clinic varies greatly from one to the next."

The general theme of many of the replies is expressed in one of them: "Efforts to develop facilities, especially for those who cannot afford private services, have been made and have obtained a degree of success, but many gaps remain, both in types and in volume of services. The problem has been compounded by such factors as the extremely rapid population growth in our county, by its political structure and attitudes, and by difficulties in having all the interested groups and agencies follow a unified and coordinated plan of development." The survey certainly indicated the presence of great problems and the need to mobilize resources to meet those problems, but also indicated that beginnings had been made, and that there were physicians interested and involved in continuing this work.

523 Forest Avenue

The road to death need not only be a oneway street.

Death And The Road Back*

Arthur Winter, M.D./East Orange

Why do we need a new definition of death? At what point can the patient "return to life" because of our modern devices, with or without neurologic deficits; or will he continue into the inevitable status of death? I will describe several cases in which there was severe brain damage and the patients were dying, and there was no chance whatsoever of their returning to life. I will describe other cases of patients who appeared to be dying and, yet, were able to return with minimal neurological deficits.

Case One — A 19 year old Marine was admitted to St. Barnabas Hospital after sustaining severe head injuries in an automobile accident. On admission, he responded briefly but was semi-comatose. His pupils were dilated, fundal vessels were engorged and he had blurring of the discs indicating increased brain pressure. His scalp was almost completely detached from the skull because of the deep injury. He was bleeding profusely. At times, there were some spontaneous movements in the lower extremities. Pressure dressings were applied. X-rays disclosed an older occipital wound due to mortar fragments and super-imposed on this, a fracture line from the second injury. Diagnoses were cerebral concussion, laceration of the scalp, and mortar fragment injury to the skull. The patient was given antibiotics and tetanus antitoxin and we took him immediately to the operating room to repair this deep laceration and to see whether he had subdural hematoma. Burr holes disclosed an acute subdural hematoma and the laceration in the scalp was repaired.

He never regained consciousness. His pupils showed some reaction to light on the first postoperative day. Vital signs remained stable for 24 hours and he was given vigorous treatment which included hypothermia, antibiotics, steroids, but in spite of all this, his condition seemed to deteriorate. That evening the patient had a respiratory arrest and then a transient cardiac arrest. In the intensive care unit, a closed chest massage was carried out and an endotracheal tube was hooked up to the respirator. His pupils did not become fully dilated at that time but there was a gradual dropping in his blood pressure to hypotensive levels. We gave him Mannitol® and intravenous Solu-Cortef®. We took him back to the operating room to determine whether he was re-bleeding or whether he had massive brain edema. The flap was turned and it was evident that it was massive brain swelling in spite of all methods that we used. The brain literally started coming out of the defect in the skull. His postoperative course was that of gradual deterioration due to massive brain injury, secondary cardiac arrest and respiratory arrest and, therefore, irreparable brain damage.

This was a case in which there was irreparable damage to the brain, secondary to his severe head injury. A healthy young body with a dead brain, he was a possible donor for organ transplantation. His father's remark was, "Doc, the kid has to come home from Vietnam to get killed!"

Case Two — A 44 year old man was admitted to the hospital because of severe frontal headaches for the last two weeks. An ophthalmologist found papilledema and unilateral hemi-anopsia. He had an equivocal right facial droop, blood pressure was 160/70, pulse was 78. He had some pain on flexion of his head with some question of nuchal guarding. The patient was obtunded and he had some difficulty doing serial sevens.† The impression at this time was that he definitely had increased intracranial pressure possibly due to vascular subarachnoid bleeding because of the nuchal guarding or possible brain tumor. At lumbar puncture, pressure was 180, ten red cells, but no white cells. Protein was 92 and sugar 124.

Left carotid arteriogram, EEG, and brain scan revealed a very large temporo-parietal lesion (See Figure 1). We did a craniectomy for biopsy of the lesion which proved to be a malignant brain tumor, a grade 3 astrocytoma (See Figure 2). Post-operatively, he did very well. On radiation therapy, he continued to improve for six months. His headaches disappeared. Then, there was evidence of recurrence and, in spite of radiation and chemotherapy with Actinomycin D, the patient's course became worse and he died.

In these two cases, the outcome was determined. One death was due to a severe brain injury and the other to a malignant tumor. In this latter case, it would have been senseless to prolong his suffering. In fact, the wife gave permission at this time for heart transplant.

Here are other cases which did approach death but could return with varying results.

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* Opening paper of the symposium on the Diagnosis of Death, presented May 18, 1969, at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, New Jersey.

† The patient is asked to subtract 7 from 100, then 7 from 93, then 7 from the remaining 86, and so on.

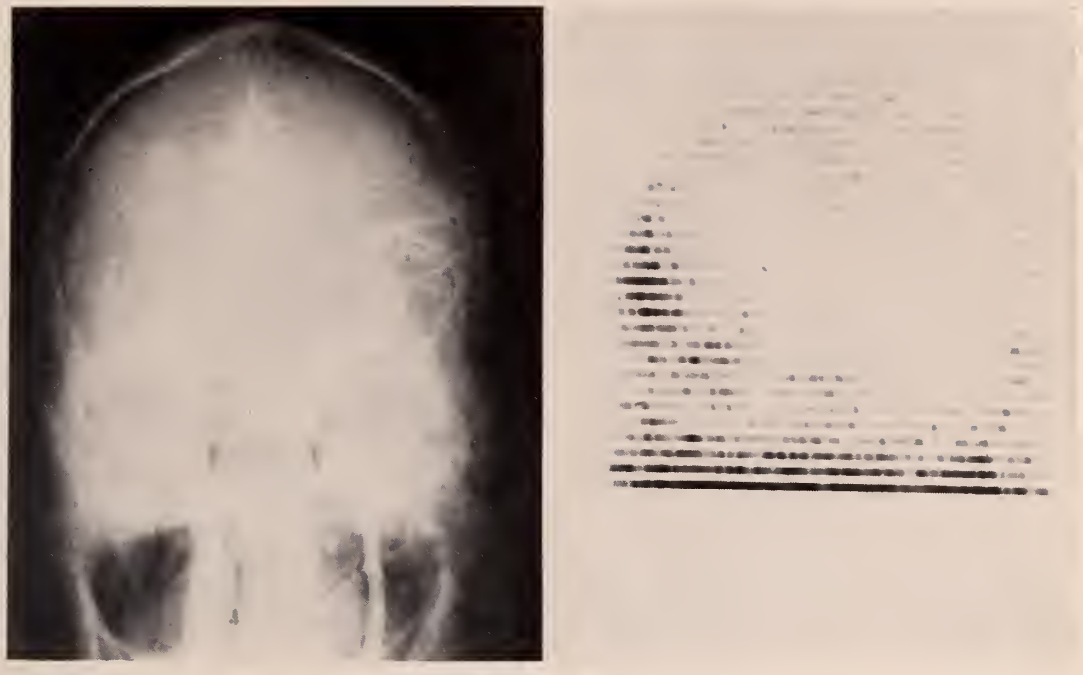


Figure 1 — This shows an arteriogram in the AP view on the left and a brain scan with Tc-90 in PA views showing increased uptake over the left parietal region. The description of the arteriogram shows the anterior cerebral artery to be shifted from left to right and there is upward displacement of the middle cerebral artery indicating a deep vascular left parietal lesion. On the brain scan, this is also evident.

Case Three — A 6-year-old girl was hospitalized after being hit by a car. She had been thrown a distance of 50 feet and was rendered suddenly unconscious. She remained in the hospital for a week where a tracheostomy was performed. She was treated with hypothermia because of a temperature raging up to 106. She showed evidence of fractured ribs, fractured right humerus, and a comatose state. Our impression was, with her multiple fractures and coma, that she looked like a "broken doll." Brain scan, electro-encephalogram and other diagnostic studies indicated increased pressure over the right temporal area. At subtemporal decompression, we noted marked swelling of the surface of the brain but no evidence of subdural hematoma. Seven hours post-operatively the child seemed to respond to painful stimuli and became more alert.

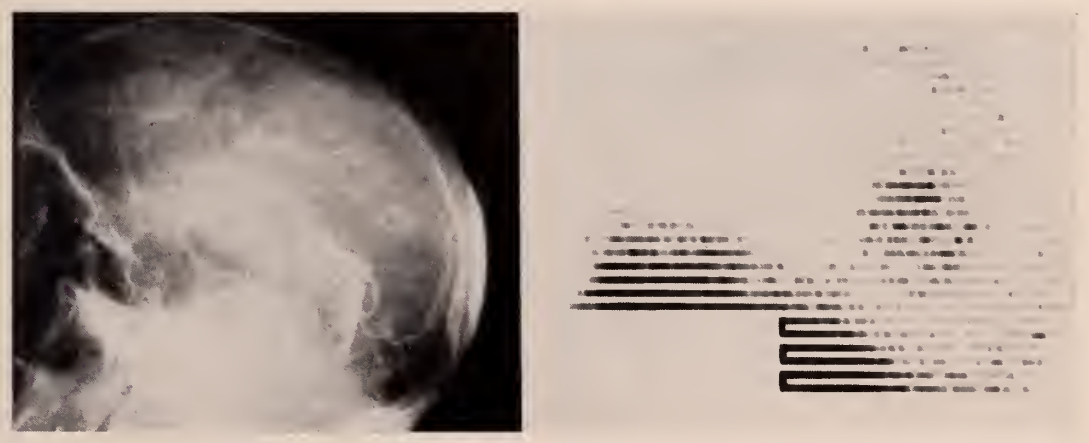


Figure 2 — In lateral view, of the arteriogram and brain scan, the highly vascular malignant tumor is well outlined and demarcated on the left. In the brain scan there is increased uptake outlining exactly the tumor stain seen in the arteriogram.

There was a gradual decrease in her spasticity and she started to respond to sound. The child became progressively more alert and, was given carbon dioxide therapy to increase the vascularity to her brain and hyperbaric treatment with steroids. As each day went by, she became brighter. Suddenly one day, she smiled. With her eyes she was following the examiner about the room and within three weeks she could obey commands. Then, there was evidence of spontaneous laughter. She could now respond to questions by nodding her head and verbalizing. Then she recognized her mother, and daily there was improvement in her vocabulary and conceptual ability. The child finally was taking feedings by mouth, her words increased to sentences, recognition and personality improved and she was discharged. She continues to improve now five months after her initial injury in which she was deeply comatose. The diagnosis here was laceration of the brain, cerebral concussion, multiple fractures of the femur, ribs, and abrasions. Here was a case with residual deficit though, in spite of all that was done.

Case Four — A 37-year-old female was brought into the emergency room in coma as a result of falling out of a second-story window. Apparently, she had tried to commit suicide by taking an overdose of drugs. She locked herself in the bathroom, slashed her wrists, and jumped out of the second-story window. When she arrived in the emergency room, she was in shock. Blood pressure was 70/0, the pulse was thready, and the patient was bleeding from her right ear and scalp and slashed wrists. The pupils were dilated and she was showing decerebrate posturing. The impression was that she had a brain laceration and was in shock from the profuse bleeding from her scalp and wrists. She also had a basilar skull fracture. The patient was given plasma and whole blood to maintain her blood pressure. X-rays revealed a fracture of the skull in the temporo-occipital region on the right. There was the possibility of an epidural hematoma too. Burr holes were made, using the anterior portion of the fracture line as a clue for possible epidural bleeding. There was no epidural hematoma, but, as soon as the burr hole was made, it was found that the patient had acute subdural bleeding. Just prior to the operation, the patient was on the stretcher and we were shaving her hair. At this point, she had a sudden cardiac arrest. We began immediate cardiac massage and then started to defibrilate her. We felt, of course, the patient had expired but, because of her age and the type of injury, I continued and made the first burr hole over the area described. As soon as the dura was open, the subdural hematoma burst, spurted out under pressure, and evacuated itself. Then, the patient's cardiac rhythm and heart beat returned to normal and became spontaneous. The brain surface itself was purplish in color indicating underlying severe brain damage.

She gradually improved to the point where she did recognize her parents. With intensive physiotherapy and care, she learned to walk again but there is a great deal of personality change here. At one time, she had been a pretty talented young lady and had actually been a singer on television. The personality had changed since her injury in that she was uninhibited in her language, saying whatever came to mind, and required constant nursing care because of the suicide attempt. At her last evaluation, I saw her in a nursing home. She was walking by herself. She did recognize some people, but there was still evidence of severe brain damage. There was, according to the follow-up history, some continued but slight improvement since her initial injury.

With this type of patient, it was impossible to determine beforehand how much restoration of cerebral function there would be and what the final outcome would have been. Since her heart had stopped five times and had to be re-started, how many times was she really dead?

Case Five — This six-year-old girl was a passenger in her mother's car. The front tire blew out and the car ran into a telephone pole. When she was brought into the hospital, she was comatose, bleeding from her ears and nose. She had dilated pupils, became apneic and then started a convulsive seizure of the left side of her body. She had, at this time, severe swelling over the right side of her face and jaw and it looked as if she were going to die within the next 20 minutes. I immediately gave her intravenous Dilantin,® Solu-Cortef,® and Mannitol.® We took her to the operating room. This all took place within a period of about 38 minutes. As soon as the dura was opened the spinal fluid shot out under pressure. It was then evident that this skull was depressed at almost two centimeters into her brain. After the Mannitol® was administered, and the decompression operation completed, the surface of the brain started to pulsate. Her color improved. We then put her on steroids, Chymoral,® Dilantin® and intravenous fluids. Within eight days, she began to verbalize. The tracheotomy cannula was removed.

She is now attending school and is doing very well in her school achievement.

Here is a youngster, where it looked as if the moment of death was very close. Yet, because of the excellent cooperation of the house staff, and operating room, we were able to reverse the procedure and bring her back to normal function.

Case Six — A 71-year-old woman was found comatose by the police in her apartment. There was a garage under her apartment, and a driver put his car in and forgot to shut off the ignition. This left the car running. The couple on the second floor above noted severe headaches and nausea and opened the windows, felt better, and notified the police. The couple then remembered that there was a widow on the first floor above the garage. The police broke in and the woman was found in deep coma. The car had been running for hours. The comatose state was due to carbon monoxide poisoning. At the hospital she was treated with medication to reduce brain swelling, and with hyperbaric oxygenation. When I saw her in the hospital, she was comatose, completely unresponsive to any stimuli, her pupils were in moderate dilatation and her prognosis was very poor. But then, she showed a gradual cerebral function return to the point where she did improve a great deal. Figure 3 shows her image performance which she made for the psychologist. This was a clue to her increased cerebration. The figures that she first drew seemed to be fetal in nature. They developed to a point in the consequent drawings where they picture an adult with proper extremities.

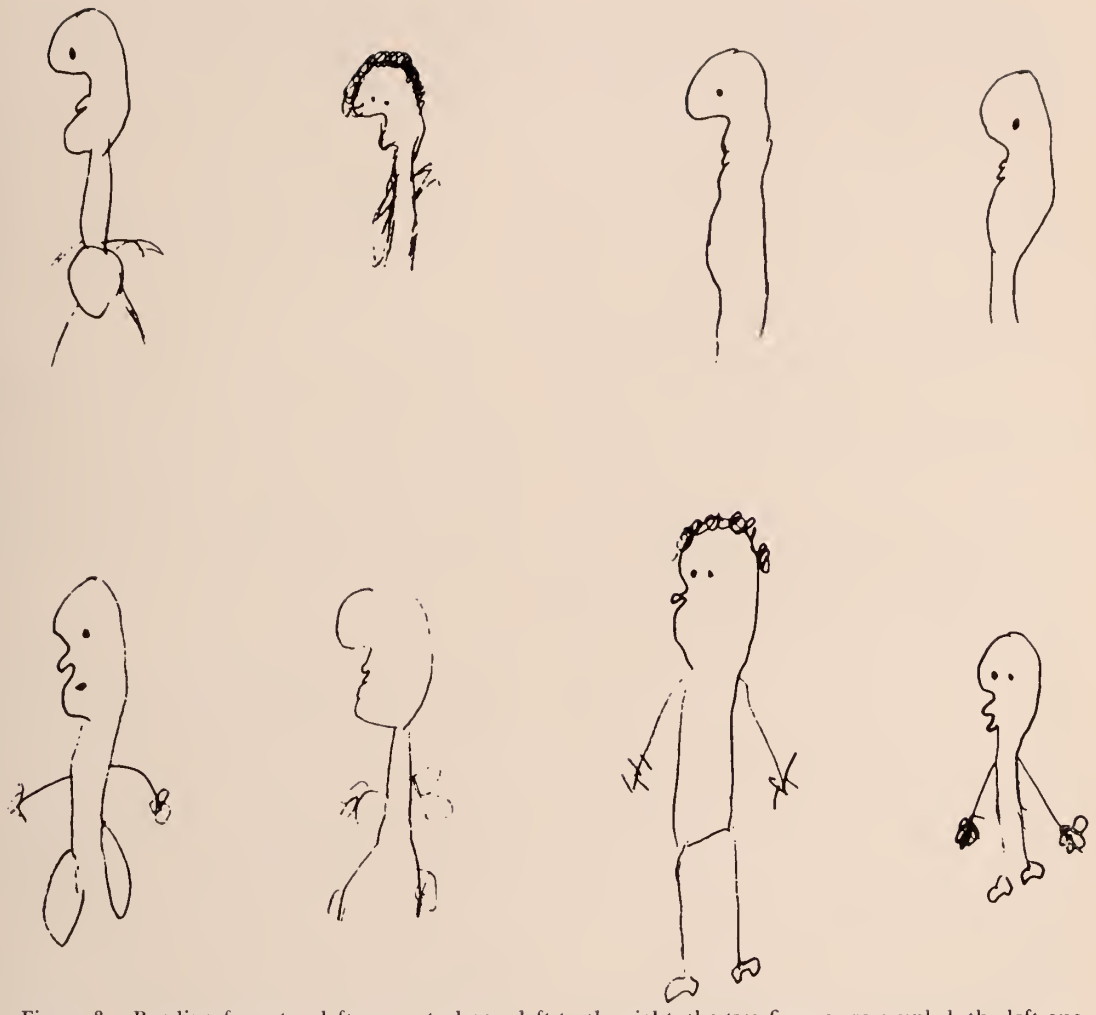


Figure 3 — Reading from top left across to lower left to the right, the two figures are coupled, the left one being a woman, the right one being the man. This shows the return of normal cerebral function. Comparing the first set of drawings to the last, you can notice that in the first set there is a paucity of detail and this proportion in the size of the head to the body, with a lack of hair and the number of anatomical parts. As can be seen in the last set of drawings, the patient's clinical improvement was marked and it clearly outlines the return to normal function in a period of about four weeks.

Here is a patient who seemed to be on the verge of death from carbon monoxide poisoning but she was able to be restored to complete normal functionng.

There really are criteria for a new definition of death and it becomes important at this time because of the possibility of organ transplants. According to the *ad hoc* committee at Harvard, specific defined conditions are necessary to pronounce a patient dead. They are:

1. Unreceptivity and unresponsivity. The patient is unaware of any stimuli and does not respond to them.

2. No movements or breathing. If the patient is on a respirator and there is no breathing after it has been stopped for a period of 3 minutes, it is obvious that he is not breathing by himself.

3. No reflexes. The pupils are dilated and fixed. They do not respond to any source of bright light. Irrigation of the ears does not produce any head turning or ocular movements.

4. A "flat" electroencephalogram is to be checked so that it remains isoelectric at double

the standard gain which is 5 microvolts per millimeter. At least ten full minutes of recording are required but the *ad hoc* committee suggests that they be done for at least 20 minutes. There also should be no response on the electroencephalogram to external stimuli such as noise or skin pinching; these stimuli ordinarily do provoke changes on a normal brain.

All the tests mentioned above should be repeated at least 24 hours later. The EEG may be modified, however, by toxic conditions such as hypothermia, or drugs such as barbiturates, and this must be excluded before accepting just the EEG.

In their report, the committee suggests that: "The patient's condition can be determined only by a physician. When the patient is hopelessly damaged, his family and all colleagues who have participated in major decisions concerning the patient, and all nurses involved, should be so informed. Death is to be declared and the respirator turned off. The decision to do this and responsibility for it is to be taken by the physician in charge, in consultation with one or more physicians who have been directly involved in the case. It is unsound and undesirable to force a family to make a decision."

Of course if the family does not want the doctor to turn the mechanical devices off, he should respect their wishes.

The physician who does declare the patient dead and turns off the respirator is not to be connected in any way with any transplantation procedure. This is to avoid any whisper of self-interest by the physicians involved. Personally, I think that the defined 24 hours (as suggested by the *ad hoc* committee) is a long time to wait with patients pronounced dead; that if the brain lives only five to ten minutes, at most, during an anoxic state, that an hour be considered as time sufficient when all the criteria are fulfilled as defined by the Harvard group.[2]

Summary

Obviously, some people enter the state of coma and are near to the status of death, but yet return. Some who return can come back to a normal life. Others may come back with some or a great deal of neurologic deficit. It is important to determine which of these will come back and how much deficit they will have.

In the first two cases above (irreparable brain damage and a malignant brain tumor) we are able to define death and fulfill the criteria as indicated by the *ad hoc* committee of Harvard. The definition of death and its new criteria must be considered because of its relationship to newer concepts involving organ transplants. We must say that: *When the brain has died the patient has died!* This cannot be defined as euthanasia because the patient is dead and the physician has not interrupted life!

References

1. Special communication: *JAMA*, 205:337 (August 5, 1968)

2. Winter, Arthur: *The Moment of Death*, Charles C. Thomas, publisher (in press)

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

October 19, 1969

A regular meeting of the Board of Trustees was held on October 19, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Representation for RNs in Negotiations with State of New Jersey . . . Recommended that medical professional employees of the State of New Jersey have separate professional representation in negotiations with the State; and referred correspondence on this subject from the New Jersey State Nurses' Association to the MSNJ Tri-Partite Committee for study.

. . . Directed that either the Executive Director or the Executive Assistant represent MSNJ at the hearing on this subject scheduled for October 24.

The actions above listed are in response to a request from the New Jersey State Nurses' Association for certification as exclusive agent for all registered nurses employed by the State of New Jersey, within the Department of Institutions and Agencies. This is opposed by the State on the basis that representation of professionals should be by a single organization on a statewide basis for *all* professional employees.

Death Certificates . . . Recorded its opinion that physicians should not sign death certificates until all identifying statistical information has been entered theron; and directed that this information be called to the attention of the membership.

This action is in response to a communication from the Registrar of Vital Statistics calling attention to the fact that some physicians signed death certificates before they had been completed.

Council on Legislation . . . Approved the report of the October 16 meeting of the Council on Legislation, including the following recommended official position of MSNJ on bills of medical import:

S-710—Excuses any public school pupil from attending any sex education class if parent or guardian objects. *APPROVED*

S-814—To define "school of professional nursing" to mean a school offering a program of nursing instruction not exceeding four, in place of three, years and to delete from such definition the phrase "is affiliated with a hospital." *ACTIVE OPPOSITION*, because in 1967 the Society approved S-409, which became law and which made available State funds to diploma nursing schools in order to encourage those schools of professional nursing to remain open and to enlarge their facilities and enrollments, thereby assuring a continuing supply of registered nurses. This bill—S-814 of 1969—would have the opposite effect through deleting the words "is affiliated with a hospital . . ." Specific deletion of those words would support the interpretation that schools so affiliated are not to be entitled to share in the State funds. It also could be construed to mean that eligible schools of nursing instruction should have no formal hospital affiliation—a circumstance which would make proper training in clinical nursing impossible, and would vitiate the worth and acceptability of the entire program of nursing education.

S-818—To protect rights of owners in the ownership of dogs and animals, designated the "Dog Owners Protection and Licensing Act of 1969." *DISAPPROVED*, because existing law, which S-818 would repeal, has proved to be effective in rabies prevention and control. S-818 would impose increased responsibilities and costs upon State and local government without concomitant benefits to public health. Additionally, it would unduly restrict the availability of research animals, thus impeding—and increasing the costs of—research into the cause, nature, prevention, and cure of diseases in men and animals.

The Board amended the position of the Council on S-818 to *ACTIVE OPPOSITION*

S-821—Permits State aid for basic health services be provided for use in substitution for moneys expended for specific activities, positions or personnel derived from the annual expenditures of the agency for health purposes during either of the two preceding years. *NO ACTION*.

S-833—To appropriate $6,000,000 to the Department of Institutions and Agencies from the Public Building Construction Fund for residential treatment facilities for narcotic addicts and drug abusers. *APPROVED.*

A-1046—Provides that abuse of a child shall include the care and custody of a child by a parent or other person convicted of any crime or offense relating to the use, possession, sale, transportation or other dealing in or with narcotic drug; prescribes persons who may originate proceedings concerning child abuse. *DISAPPROVED,* because there is no dependable logical constancy in the presumption that a parent or guardian convicted of "any crime or offense relating to the use, possession, sale, transportation or other dealing in or with narcotic drugs" would be *per se* guilty of child abuse. Furthermore, some of the individuals granted the right to initiate proceedings under the bill do not possess requisite educational and clinical experience to determine that the resultant injury was not accidental.

The Board ammended the position of the Council on A-1046 to *DISAPPROVED WITH ACTIVE OPPOSITION, IF THE BILL MOVES.*

A-1049—To provide that any duly incorporated association, organization, league, society or other group created for the purpose of protecting dumb animals shall have the same rights, powers and privileges as are vested in the New Jersey Society for the Prevention of Cruelty to Animals. *DISAPPROVED,* because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed—or is failing—to perform its responsibilities in enforcing those laws.

A-1099—Designated the "Pesticide Control Act," creates a Pesticide Control Commission in the Department of Health to regulate and control the use and sale of pesticides. *NO ACTION.*

The Legislative Analyst informed the Council that —by executive order—the Governor appointed a "Pesticides Advisory Council" under the aegis of the State Department of Agriculture to investigate the use of pesticides, insecticides and herbicides for their effect on the total environment. The Governor's Council is to report in January 1970. For this reason, the Council recommended a position of "no action."

Chiropractic . . . Approved a proposed draft of legislation to prohibit the future licensing of chiropractors in New Jersey (as directed by the 1969 House of Delegates) for introduction in the 1970 Legislature.

. . . Directed that this draft be circulated among the component county societies.

Audit Review . . . Approved the report of the special committee to review the 1968-1969 audit, including the recommendation that a copy of the annual audit and the minutes of the Audit Committee be forwarded to each of the component county societies.

Joint Conference of County Society Presidents . . . Met with the members of the Conference of County Presidents and discussed the following items from the agenda of their morning meeting: (1) creation of and/or accomplishment of County Society Committees on Medicine and Religion; (2) attendance of MSNJ Officers at meetings of county societies; (3) entertainment on Saturday evening of the 1970 annual meeting; (4) willingness of county societies to agree to a change in MSNJ Bylaws to permit the Nominating Committee to meet at some time other than the presently stipulated "evening of the first day;" (5) feasibility of physical examination of applicants for automobile insurance and advisability of re-examining all drivers over 65 years of age (referred to the Commitee on Traffic Safety); (6) immunization programs for rubella; (7) interval between booster shots of tetanus toxoids (referred to the Council on Public Health); (8) inconsistency of fiscal intermediary in approving payments under Medicare; (9) limits within which component societies may act on political and educational endeavors without MSNJ supervision or support (The board stated that county societies are autonomous within their own borders, as long as their activities are not in conflict with the Constitution and Bylaws of MSNJ and its official programs, policies, or positions); (10) prescriptions issued by unlicensed interns and residents (referred to the State Board of Medical Examiners); and (11) procedures under Blue Shield coverage—payment for care of patients transferred to an extended care facility, payment for consultations, fee schedule for collecting specimens under Rider J.

Pension Plan . . . Approved the Treasurer's request to engage the firm of Kruce, O'Connor and Ling to evaluate and make recommendations concerning the Pension Plan for MSNJ employees.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during October 1969.

	1969 October	1968 October
Aseptic meningitis	35	41
Primary encephalitis	1	8
Post-infectious encephalitis	1	
Hepatitis: Total	286	184
Infectious	226	145
Serum	60	39
Malaria	18	2
Military	14	2
Civilian	4	0
Meningococcal Meningitis	6	7
Mumps	89	45
German measles	27	8
Measles	38	40
Salmonella	62	32
Shigella	40	22

Rubella Vaccine

Large scale rubella immunization programs among school children have been initiated this month by the New Jersey State Department of Health. To date, programs involving kindergarten through fourth graders have been completed in Hoboken, Jersey City, and Trenton. A similar program will be conducted in Newark in December.

The New Jersey State Health Department is interested in adverse reactions to the rubella live virus vaccine. These include local reactions at the site of injection, fever, arthralgia and/or arthritis (particularly among postpubertal females), pregnancy, and rubella-like illness in a contact of the vaccinee. Please call the Acute Communicable Disease Control Program at 609-292-7300 about any such suspected complications.

All females in the child bearing age group should be screened for antibodies to rubella prior to receiving the vaccine, since approximately 85 per cent have achieved natural immunity. A hemagglutination inhibition serologic test for rubella antibodies is performed by the Virology Laboratory of the New Jersey State Health Department as a service to physicians throughout the state. Before administration of vaccine to a postpubertal female, the physician must be assured that the patient is not pregnant and will not become pregnant in the next two months.

Malaria

As of October 18, 2459 cases of malaria have been reported throughout the entire United States in 1969, contrasted to 1874 cases reported during the same period in 1968. One hundred seventeen cases have been reported from New Jersey thus far in 1969. The majority of case reports are from military personnel who have returned from South East Asia. The civilian cases have occurred among people who have traveled in malarious areas, particularly recently discharged military veterans. Recently, two cases have been reported in persons who were hospitalized outside of the U.S. and who received infected blood. (MMWR 18, Sept. 12, 1969).

Four species of malarial parasite are pathogenic for man: plasmodium falciparum, p. vivax, p. malariae, p. ovale. Infection with p. falciparum is more dangerous than the other forms since agglutinated masses of parasitized red blood cells may cause capillary obstruction throughout the body. Depending upon the extent of organ involvement, localizing signs may be produced that may suggest other disease processes, such as cerebral malaria with hemiplegia or convulsions, and pulmonary involvement with blood streaked sputum mimicking other pulmonary processes. Blackwater fever constitutes the most life-threatening complication of falciparum malaria. Although the exact precipitating cause is unknown, its onset is heralded by massive intravascular hemolysis with hemoglobinuria. Oliguria and acute renal failure rapidly ensue, leading to uremia.

In this era of widespread air travel, the necessity of obtaining a good travel history in patients with unexplained febrile illnesses cannot be emphasized enough, especially among young adults who may have served with the Armed Forces in Viet-Nam. If the index of suspicion exists, the diagnosis will be made by examination of appropriate blood smears for malarial parasites, and appropriate therapy can be instituted.

Sex Education in Public And Parochial Schools

"In the area of sexual activity," said our President, Nicholas A. Bertha, "ignorance is not bliss." Speaking before a joint legislative committee in Trenton on August 14, 1969, Dr. Bertha pointed out that, in furtherance of its purpose to advance the health and well-being of people of all ages and in all situations, Medicine has long recognized and emphasized the indispensable importance of imparting full and accurate information to the individual in order to enable him to exercise intelligent control over his life and actions. It is both the satisfaction and tragedy of human life that the health of body and peace of mind that as individuals we experience, in large part we bring about ourselves. To serve ourselves and society well we must know what we should know and do what we should do. Education is the process calculated to so equip us.

The parent is the natural guardian of the child, and basically it is the parent's responsibility to so teach, guide, and treat the child as to insure its full, harmonious, and happy development. Because of the advance of knowledge made possible by scientific investigation and because of the increasing complexity of daily living, from the earliest times parents, recognizing the limitations of their own knowledge and capabilities, have turned to other agents and agencies to assist in the proper education and development of their offspring. The physician, the clergyman, and the teacher are outstanding among those, who through the centuries, have, with the consent of parents, shared in taking care of their children.

The question which we are here considering is, "What should be the role of the school in the sex education of children?" Some parents feel that that role should be nil. Others feel that it should be minimal. Still others feel that it should be total. All will agree that ignorance of the nature and responsibility of sexual activity can and does produce tragic consequences in terms of diseased bodies, distressed minds, and shattered family and social relationships. What advice has organized medicine to offer to eliminate such ignorance and the dark consequences which it produces?

At its recent convention in New York City, the American Medical Association adopted the following resolution as an expression of its advice in this regard:

Whereas, the traditional sources of sex information and guidance for young people are often inadequate; and

Whereas, the local public and parochial schools—as social institutions accessible to all young people, reflecting broad community support and with sufficient intellectual and material resources—can aid substantially in the development of sound individual codes of sexual behavior; therefore be it

RESOLVED, that the American Medical Association recognizes that the primary responsibility for family life education is in the home, but that the AMA supports in principle the inauguration by State Boards of Education or school districts, whichever is applicable, of a voluntary family life and sex education program at appropriate grade levels:

(1) as part of an over-all health education program;

(2) presented in a manner commensurate with the maturation level of the students;

(3) following a professionally developed curriculum foreviewed by representative parents;

(4) including ample and continuing involvement of parents and other concerned members of the community;

(5) developed around a system of values defined and delineated by representatives comprising physicians, educators, the clergy, and other appropriate groups; and

(6) utilizing classroom teachers and other professionals who have an aptitude for working with young people and who have received special training; and be it further

RESOLVED, that local organizations be urged to utilize physicians as consultants, advisors, and resource persons in the development and guidance of such curriculum and that state and county medical associations be urged to take an active role in this participation.

This statement recognizes that the primary responsibility for family education resides in the parents and belongs in the home. That responsibility may at their discretion be reserved to themselves by individual parents who wish not to assign it to, or share it with, others. However, for those who prefer to use the assistance of a family life and sex educa-

tion program conducted in the schools, this declaration recommends that such a program be made available—but on a voluntary and not a compulsory basis. Further, it does not feature the school family life and sex education as a separate entity, but would incorporate it as a component of an integrated health education program.

It would supply only such information as the maturity of the student makes him or her ready and able to accept. The curriculum would be produced and presented cooperatively by representative parents and representative professionals, counseled and advised by physicians, clergymen, educators, and other qualified community members. Only well trained, selected professional personnel would be designated to conduct the agreed-upon program in the classrooms.

With all these built-in safeguards, this proposal of organized medicine suggests the means whereby a program can be evolved, in local communities, compatible with the wishes and approved norms of the communities, and sufficiently tempered to avoid the excesses of prudery on the one hand and of prurience on the other.

In the area of sexual activity, ignorance is not bliss—whether that ignorance be of physiological facts or of moral and social standards. Proper, balanced knowledge of all considerations that make for a full, decent, and dignified mature human person must be supplied. With the true happiness of our sons and daughters and the peace of contemporary society as our goals, we should and must work together.

The Medical Society of New Jersey has commended the New Jersey State Department of Education for its work in this area. The *Guidelines* which it produced will, under the AMA proposal, be subject to the consideration of those responsible for evolving and presenting agreed-upon programs in their local schools. As such they should prove to be of practical value.

Funds Needed For Supporting M.D. Privilege Bill

In 1967, communications between clients and psychologists were legally "privileged and confidential" but communications between patients and M.D. psychiatrists were not. At that time, any physician could be brought into court, and compelled (by a threat of a "contempt" citation) to tell the jury what a patient had told him in confidence. This is not true today because of legislation passed last year that put New Jersey physicians in the same class as those in Pennsylvania and New York—that is, in the category of those who, like priests, are legally entitled to such "privilege."

One factor in having this law passed last year was the courage of one of this Society's members in refusing to divulge a confidence in spite of a court order. First the trial court held him in contempt for being unwilling to report what he had learned in confidence. Then the Appellate Division refused to disturb this finding of contempt. The Supreme Court finally vindicated the doctor and this, in all probability, was the final thrust that led to the enactment of our "privilege" law.

The doctor who went through all this is out-of-pocket by the several thousand dollars needed to finance the appeals and pay legal fees. Yet his courage and persistence has benefited all New Jersey doctors. So, an appeal is made by the Society of Clinical Psychiatrists for contributions to help defray some of this expense. Make the check payable to the Society of Clinical Psychiatrists and send it to the Treasurer, Thomas Smith, M.D., 385 South Maple Avenue, Glen Rock, New Jersey 07452.

Scientific Exhibit
Application Blank
See page 682

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—Richard Helfant, M.D., Peter Bent Brigham Hospital, Boston, Massachusetts 02115. NYU—Bellevue 1963. Board eligible. Cardiac catherization laboratory in hospital. Available July, 1970.

Edgar Lichsten, M.D., 300 Kensington Avenue, New Britain, Connecticut 06050. NYU (Downstate) 1961. Board certified in Internal Medicine. Full-time position in cardiology. Available January 1970.

DERMATOLOGY—Frederic R. Rothman, M.D., 413 College Parkway, Rockville, Maryland 20850. Michigan, 1964. Board eligible. Partnership or group. Available July 1970.

David J. Tuckman, M.D., U.S. Darnall Army Hospital, Fort Hood, Texas 76544. Hahnemann, 1964. Board certified. Group, partnership, or solo. Available July 1970.

GENERAL—Richard D. Hasz, M.D., 1535 Sixth Street, Waynesburg, Pennsylvania 15370. University of Buffalo 1963. Board eligible. Solo or partnership. Available August 1970.

Robert J. Ailes, M.D., 72 Van Allen Road, Glen Rock, New Jersey 07452. Western Reserve 1964. Group, hospital, or industrial (part-time only) Available.

INTERNAL MEDICINE—Chaim Charytan, M.D., 109 Eastridge Drive, San Antonio, Texas 78227. Einstein College of Medicine, 1964. Board eligible. Subspecialty, nephrology. Solo, partnership, group, or institution. Available July 1970.

Noel I. Robin, M.D., 19 Lake Shore Court, Brighton, Massachusetts 02135. Downstate Medical Center (NYU), 1965 Board eligible. Subspecialty, endocrinology. Group (teaching hospital and medical school affiliation). Available July 1970.

Barry R. Zitomer, M.D., 14501A DelAmo Street, Santa Ana, California 92705. Pennsylvania 1963. Board eligible. Partnership or group. Available July 1970.

Stephen H. Jacobs, M.D., Quarters 8620, Fort Lewis, Washington 98433. Georgetown 1964. Board eligible. Group or partnership (preferably Bergen County). Available August 1970.

Aaron Weisberg, M.D., 1060 Ocean Avenue, Brooklyn, New York 11226. Cincinnati, 1939. Board Certified. Group or partnership. Available January 1970.

Allen Chinitz, M.D., 650 West 64th Drive, Hialeah, Florida 33012. NYU (Downstate) 1961. Board eligible. Solo, partnership, or group. Available September 1970.

NEUROLOGY—Steven L. Eisen, M.D., 165 West End Avenue, New York 10023. Albany 1966. Board eligible. Solo, partnership, or group. Available June 1970.

Harvey H. Kornblit, M.D., 1906 Wyndale, Houston, Texas 77025. Zurich (Switzerland) 1956. Solo, associate (full or part-time), or group. Available.

OBSTETRICS AND GYNECOLOGY—Stan P. Smith, M.D., 3702A Spruce Street, Dover, Delaware 19901. Temple, 1964. Board eligible. Partnership. Available September 1970.

Michael Mandell, M.D., 296 Duncan Court, Loring AFB, Limestone, Maine 04750. Albert Einstein 1963. Board eligible. Group or partnership. Available July 1970.

OTOLARYNGOLGY—Robert P. Plotkin, M.D., 145 Fourth Avenue, Apt. 4E, New York, New York 10003. Wisconsin, 1962. Board eligible. Associate. Available July 1970.

PEDIATRICS—Franz Hummert, M.D., 58 Pine Grove Terrace, Newark 07106. Muenster, West Germany 1961. Board eligible. Group or partnership. Available November 1969.

Deborah Chernock (Block), M.D., 536 Wyndham Road, Teaneck, New Jersey 07666. University of Chicago, 1966. Associate or group. Available.

Phil Brunner, M.D., 5 Clipper Road, Palos Verdes Peninsula, California 90274. NYU (Downstate) 1965. Board eligible. Group. Available August 1970.

PHYSICAL MEDICINE—Peter T. Han, M.D., VA Hospital, Department of PMRS, Brooklyn, New York 11217. Shanghai Tung Teh 1948. Group or hospital. Available January 1970.

SURGERY—Pun Fai Yuen, M.D., 413 USPH Hospital, Lawton, Oklahoma 73501. St. Louis University School of Medicine, 1960. Board eligible. Group. Available October 1969.

Ali Ghazi, M.D., 195 Adams Street, Brooklyn, New York 11201. University of Teheran, 1958. Board eligible. Associate or group. Available.

Ignacio M. Cruz, M.D., 4038 58th Street (Woodside) New York, New York 11377. University of Santo Tomas, 1959. Board certified. Group, partnership, or full time. Available.

Francisco D. Avellana, M.D., 2670 Montana Avenue, Apt. 8 Cincinnati, Ohio 45211. University of Manila 1959. Board eligible. Group partnership or solo. Available July 1970.

Richard H. Unger, M.D., 106th General Hospital, APO San Francisco 96503. Seton Hall 1963. Board eligible. Group, associate, solo. Available August 1970.

Manuel S. Garcia, M.D., 903 Hensley Heights, Man, West Virginia 25635. Santo Tomas (Manila) 1957. Board eligible. Solo or associate. Available December 1969.

The Scientific Exhibits — — 204th Annual Meeting

The following information is pertinent to the scientific exhibit displays at the 204th Annual Meeting of this Society, May 17 to 19, 1970. Those interested in participating may use the application form on page 682. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Sidney Girsh, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Regulations

1. *Time:* The exhibits will open officially at 10 a.m., Sunday, May 17, and close at 3 p.m., Tuesday, May 19. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 11:00 a.m., Saturday, May 16, and all exhibits must be in place by 9:00 a.m., Sunday, May 17. Exhibits must remain intact until 3 p.m., Tuesday, May 19, and should be removed from the exhibit hall not later than 12 noon, Wednesday, May 20.

3. *Cost:* The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign *(if requested)*, and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent*. The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of all exhibitors will be deeply appreciated.

ANNOUNCEMENTS

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital's continuing series on the basic sciences and clinical application will hold its January meetings on four Thursdays at 3:30 p.m. in the T. J. Summey Building of the Hospital. AAGP gives 1½ credits per session. The programs and dates are as follows:

January 8	Newer Anesthetic Agents
January 15	Medical Management of Gastrointestinal Hemorrhage
January 22	Surgical Management of Gastrointestinal Hemorrhage
January 29	Urinary Diversionary Procedures

For further information please write to J. R. Wolgamot, M.D., Director of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Plastic Surgery Program

A three-day course in plastic surgery is offered at St. Luke's Hospital in New York City, January 19, 20, and 21, 1970. Columbia University provides the academic sponsorship, identified as PM-23. The tuition is $100. All aspects of plastic surgery are included. For registration or other information, write to the Associate Dean, College of Physicians and Surgeons, 632 West 168th Street, New York 10032.

Sandoz Lectures For M.D.s

Sandoz Pharmaceuticals, with the cosponsorship of the adjacent county medical societies, is now offering a practical series of lectures, demonstrations, and conferences. The March meeting is at 9 p.m. at the Hotel Suburban in East Orange. The others are 8 p.m. at the Sandoz Auditorium in Hanover, at the intersection of Route 10 and Ridgedale Avenue, three miles west of the Livingston traffic circle.

January 29	"You Can Treat Alcoholism"—Ruth Fo, M.D.
February 11	"Gynecology In Family Practice"—Michael J. Jordan, M.D.
March 10	"The Use And Abuse Of Addictive Drugs"—Robert W. Baird, M.D.
April 2	"The Family Doctor's Role In Obesity"—Morton B. Glenn, M.D.
May 6	"Iron Absorption And Metabolism"—John Murray, M.D.

Anesthesia Seminar In March

Our State Society of Anesthesiologists will hold a graduate seminar at Cherry Hill, New Jersey on March 7, 1970. A star-studded faculty has been recruited. A registration fee of $14 includes luncheon. Interns and residents in anesthesiology are admitted *gratis*. For more information, write to Dr. Peter A. Tucci, 22 Fairway Avenue, Upper Montclair 07043.

Angiography

Columbia University announces an intensive three-day course in "Technics, Room Design, and Instrumentation for Angiography," starting on March 18, 1970. For more details about this unique and highly practical program, write to the Associate Dean, College of Physicians and Surgeons, 636 West 168th Street, New York City 10032, and ask about graduate course PM-5.

EENT—Plastic Surgery Program In Europe

During the first two weeks of May the Second Congress on Ophthalmic and Otolaryngic Plastic Surgery will hold meetings in Moscow, Leningrad, Vienna, and Rome. An excellent and unusual program has been developed, allowing ample time for sightseeing. The plane leaves New York on Friday, May 1 and will return on Sunday, May 17. For further information, write to the coordinator for New Jersey, Dr. Ralph L. Dicker, 395 West Blackwell Street, Dover, New Jersey 07801.

THE MEDICAL SOCIETY OF NEW JERSEY

204th Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 17-19, 1970

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

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3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN *not* required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15′, depth 6′.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to Sidney Girsh, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

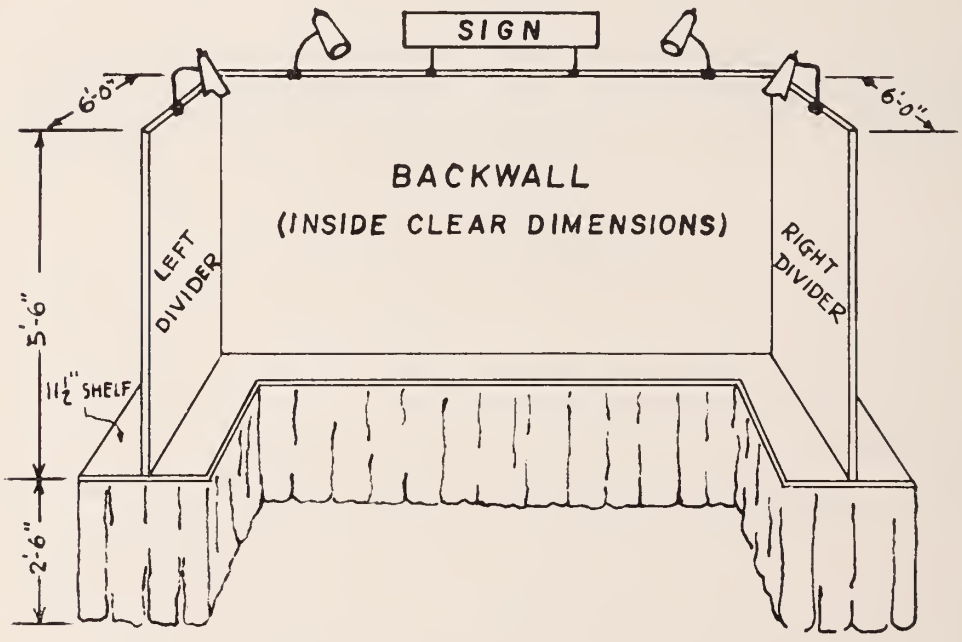
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated within your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

LETTER TO THE JOURNAL

October 31, 1969

Dear Doctor Davidson:

Upsetting as it is, I should probably not be so dismayed at seeing an article by self-styled sex-expert Mary Calderone M.D. published in the pages of our *Journal*. Her "contributions" to medical education are just another sign of the times in which we live!

There was a much earlier period in the history of our country when the Christian standard of ethics was considered the norm by the majority of our public and private institutions as well as most of our citizens. However, since the middle of the 1800's, and more particularly from the turn of the century, our people have more and more embraced the false standards of humanism, secularism, and pragmatism. Dr. Calderone delights in flaunting her humanistic amoral ideas before audiences gathered to hear her expound on the subject she loves so well—the sex education of our very young children. She is eager to point out that there is nothing really wrong with pre-marital sexual relations. The 'anything goes' philosophy constantly exudes from her smiling face.

As a Christian, I take offense at this. Being in the minority I feel that I have a right to be heard—even though I may never even begin to change the devil-may-care attitude of the present generation. Children *must* be taught the difference between right and wrong, otherwise they will be forced to find out for themselves the hard way! Because of this I am very much concerned with the ultimate effect that Dr. Calderone and her SIECUS organization will have on our children if she succeeds in putting her program across to the so-called responsible adults of our nation! Most child analysts that I know agree that too much sex education too soon will do more harm than good.

To illustrate, let me quote a few paragraphs from an article by Dr. James M. Parsons, M.D. entitled, "Sex Education vs. the 'No-No' Moralists" (Journal of the Sarasota County Medical Society—March, 1969).

"One has to assume that the SIECUS officials (Dr. Calderone is Executive Secretary of SIECUS) are simply unfamiliar with the work of the child analysts. . . . If they were familiar with the findings of the child analysts, they would not advocate their own programs. . . . The SIECUS officials behave, instead, as though unaware that their expressed dogmatism is not only unsubstantiated but directly in opposition to a great body of evidence already adduced. . . .

"We turn next to the question of whether or not they (SIECUS officials) have displayed any awareness of the experience of other countries which have implemented similar programs of 'sex education' to that which SIECUS advocated.

"One thinks immediately of Sweden, where a program remarkably similar to that which SIECUS advocates for the U.S., has been tried for many years. One can find the results quite conveniently in the book, *Sex And Society In Sweden* by Birgitta Linner (The Pantheon Press.) With all the sexual enlightenment in Sweden, one would expect that the rate of venereal disease would have plummeted, especially in view of the fact that automatic vendor machines for contraceptives now line the streets in Sweden. However, we learn on page 86 of Birgitta Linner's book that there has been an over-all increase in venereal disease. In fact . . . we find that gonorrhea now affects 14-year-olds and 13-year-olds, and the girls more so than the boys.

". . . we should expect that the more intelligent girls and boys will have been able to avoid unwanted pregnancies, especially before marriage. But we find—*mirabile dictu!*—35 per cent of all brides are pregnant on the day of their marriage. . . .

"All those years of good 'sex education' must have resulted in a higher rate of successful and happy marriages. No? No. . . . we learn that approximately 20 per cent of those reaching adult age never marry. . . .

"Does this mean that all 'sex education' is bad, and that we shouldn't tell them a thing? Certainly not."

Dr. Parsons has some practical suggestions as an alternative to the type of 'education' that Dr. Calderone is promoting. But because of limitations of space I cannot go into them. Anyone interested in reading the entire article by Dr. Parsons, and incidentally another interesting article by Dr. William C. Douglass, M.D. called "The Jet Sex," can do so by writing to these gentlemen in care of The Journal of the Sarasota County Medical Society, 311 Medical Arts Bldg., Sarasota, Florida 33579.

(signed) F. G. Ruhl, M.D.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969

December

11 **Burlington County Memorial Hospital**
Mount Holly
Common Allergic Emergencies

16 **Academy of Medicine of New Jersey**
Newcomb Hospital
Vineland
Pulmonary Problems

17 **St. Michael's Medical Center**
Newark
Pathogenesis of Fever

18 **Burlington County Memorial Hospital**
Mount Holly
Crisis Counseling

1970

January

7 **St. Michael's Medical Center**
Newark
Recent advances in Thyroid Problems

8 **Academy of Medicine of New Jersey**
Englewood Hospital,
Englewood
Symposium: Pulmonary Problems

8 **Burlington County Memorial Hospital**
Mount Holly
Newer Anesthetic Agents

14 **St. Michael's Medical Center**
Newark
Portal Hypertension Surgery

15 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Medical Management of Gastrointestinal Hemorrhage

21 **St. Michael's Medical Center**
Newark
New Concepts in Rheumatology

22 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Gastrointestinal Hemorrhage

26 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Symposium: Chemotherapy of Cancer

27 **Hunterdon County Medical Society**

28 **St. Michael's Medical Center**
Newark
Control of Acid Base Balance

29 **Burlington County Memorial Hospital**
Mount Holly
Indications and Technics for Urinary Diversionary Procedures

February

4 **Academy of Medicine of New Jersey**
Symposium on Immunology

4 to Apr. 29 Muhlenberg Hospital
Plainfield
Graduate Course in Medicine
Part II—Respiratory Diseases

4 **St. Michael's Medical Center**
Newark
Uric Acid Metabolism and Gout

5 **St. Joseph's Hospital**
Paterson
Program on Stroke

5 **Burlington County Memorial Hospital**
Mount Holly
Angiographic and Echographic Diagnosis of Genito-Urinary Lesions

11 **St. Michael's Medical Center**
Newark
Physical Diagnosis Reviewed

11 **Academy of Medicine of New Jersey**
Symposium: "Isotopes and Recent Advances in Radiologic Diagnosis"

12 **Burlington County Memorial Hospital**
Mount Holly
Management of Chronic Renal Insufficiency

18 **St. Michael's Medical Center**
Newark
The Kidney: Commonly Used Tests; Applications for Management

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Technics

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

7 **New Jersey Society of Anesthesiologists**
Cherry Hill Inn
Cherry Hill
11th Postgraduate Seminar

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

11 **St. Michael's Medical Center**
Newark
Endocrine Review

12 **Academy of Medicine of New Jersey**
Symposium: Pulmonary Embolism

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

19 **Academy of Medicine of New Jersey**
Somerset Hospital
Somerville
Symposium: Hypnosis in Medicine

20 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Pulmonary Problems

24 **Hunterdon County Medical Society**

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

2 **St. Joseph's Hospital**
Paterson
Program on Stroke

8 **Academy of Medicine of New Jersey**
Hoffman-LaRoche
Nutley
Symposium: "Surgical Management of the Mind"

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

10 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Hypnosis in Medicine

10 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Symposium: Pulmonary Problems

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May
6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

6 **St. Michael's Medical Center**
Newark
Controversies in Management of Heart Problems

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

27 **Academy of Medicine of New Jersey**
Annual Awards Dinner

June
3 **New Jersey Gastroenterological Society**
Newark

OBITUARIES

Dr. Benjamin L. Goldstein

Death came too early—at age 54—to Benjamin Goldstein, M.D., a well known Asbury Park pediatrician. In 1941, Dr. Goldstein received his M.D. at the medical school of the University of Cincinnati. He was attending pediatrician at the Monmouth Medical Center in Long Branch, and was active in child welfare affairs in the shore area. His death occurred on October 11, 1969.

Dr. Jack M. Kluft

On October 19, 1969, Jack M. Kluft, M.D. died at the untimely age of 56. Born in 1913, he earned his M.D. degree at Tulane in 1938. He worked largely in the field of internal medicine, became a board diplomate in that specialty, and was elected to Fellowship in the American College of Physicians. Dr. Kluft had a special interest in gerontology, and was active in the affairs of the American Geriatric Society and the American Diabetes Association. He was a senior attending internist at the Perth Amboy General Hospital.

Dr. Francis A. Merlo

On October 14, 1969, Francis A. Merlo, M.D., died at the age of 62. He was an alumnus of the Medical School of George Washington University, class of 1930. Dr. Merlo was active in committee work and organization affairs in our state chapter of the Industrial Medical Association and was proud to list himself as a family doctor. He was a member of the American Academy of General Practice.

Dr. Isidore Sweigel

Essex County lost one of its senior and most respected practitioners on September 20, 1969, with the death that day of Isidore Sweigel, M.D. Born in 1898, he was a member of the 1925 graduating class at the Medical School of the University of Tennessee. Dr. Sweigel was a general practitioner of the old school, and during his many decades of private practice he served on the staffs of both the United Hospitals and the Beth Israel Hospital in Newark.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Index 1969

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 66

JANUARY TO DECEMBER, 1969
Published monthly under direction of the

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This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject; book reviews, by title or subject but not by author. City of residence is indicated for authors of original articles.

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Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

in acute and chronic diarrheas

LOMOTIL® SAVES...

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate, 0.025 mg. (1/2,400 grain)

body fluids... electrolytes... patients from exhaustion

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea.

Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

gastroenteritis · acute infections · functional hypermotili
irritable bowel · ileostomy · drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy Include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:	*Total Daily Dosage*
3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. SEARLE & CO.
Research in the Service of Me

951



this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, ca tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, operati machinery, driving). Though physical and p chological dependence have rarely been report on recommended doses, use caution in ministering Librium (chlordiazepoxide hyd chloride) to known addiction-prone individu or those who might increase dosage; withdraw symptoms (including convulsions), follow discontinuation of the drug and similar to th seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potent benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibiti effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate limit dosage to smallest effective amount to p clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tol

or here.



Though generally not recommended, if ination therapy with other psychotropics indicated, carefully consider individual nacologic effects, particularly in use of po- ting drugs such as MAO inhibitors and othiazines. Observe usual precautions in nce of impaired renal or hepatic function. oxical reactions (*e.g.*, excitement, stimula- nd acute rage) have been reported in psy- ic patients. Employ usual precautions in ent of anxiety states with evidence of im- ng depression; suicidal tendencies may be t and protective measures necessary. Vari- effects on blood coagulation have been ted very rarely in patients receiving the and oral anticoagulants; causal relation- as not been established clinically.

VERSE REACTIONS: No side effects or estations not seen with either compound have been reported with Librax. When iazepoxide hydrochloride is used alone, iness, ataxia and confusion may occur, ally in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

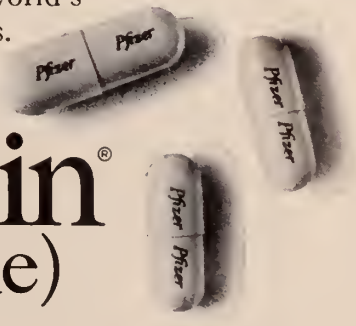
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

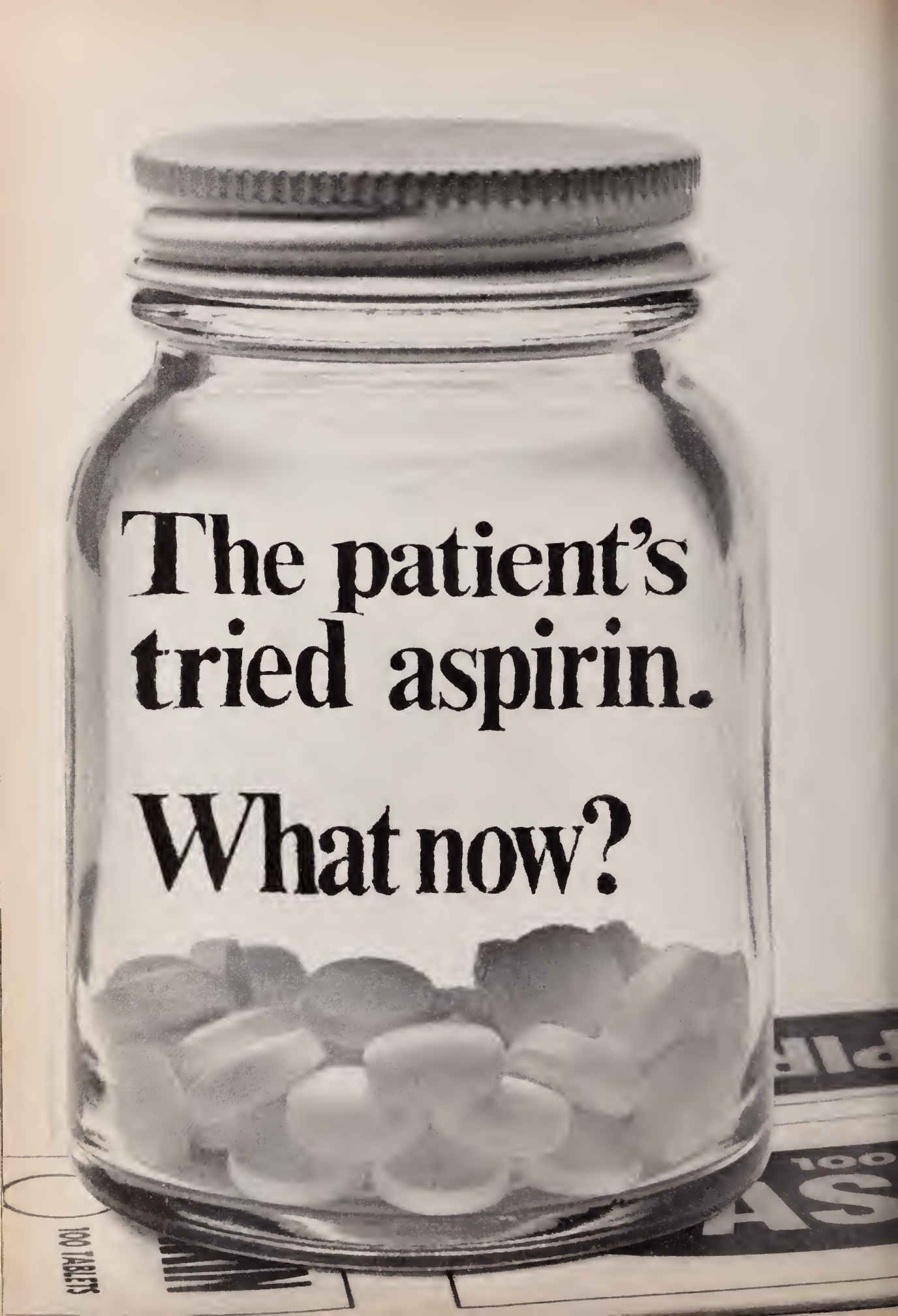
*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017


The patient's
tried aspirin.
What now?
100 TABLETS

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

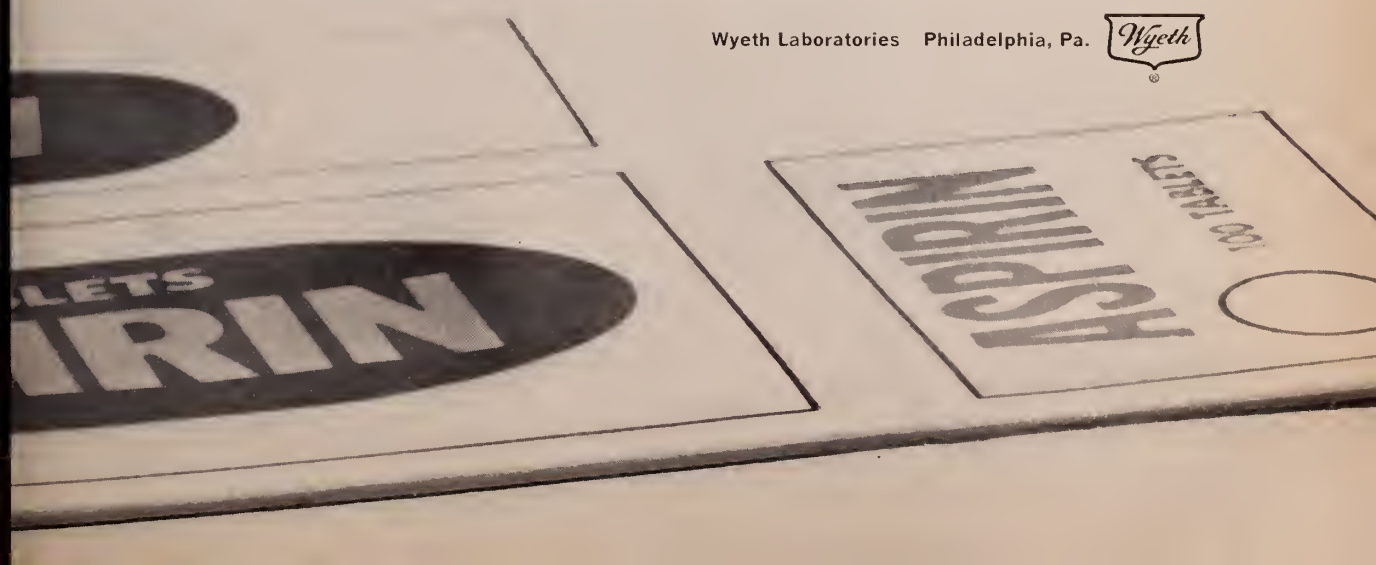
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

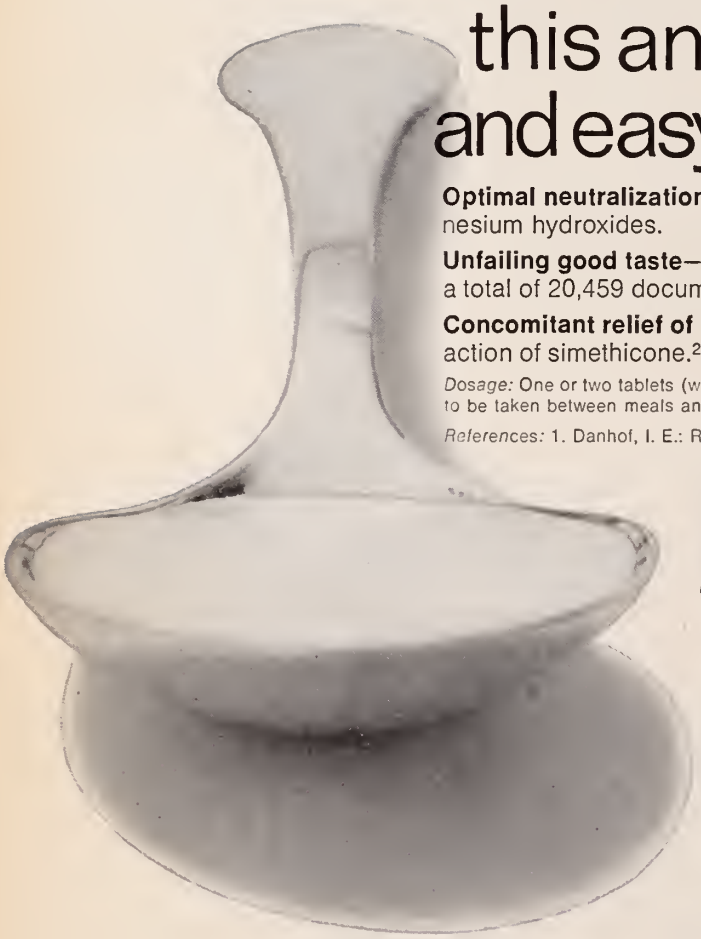
Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"*Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study*" – *Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

Android

Each yellow toblet contoins:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

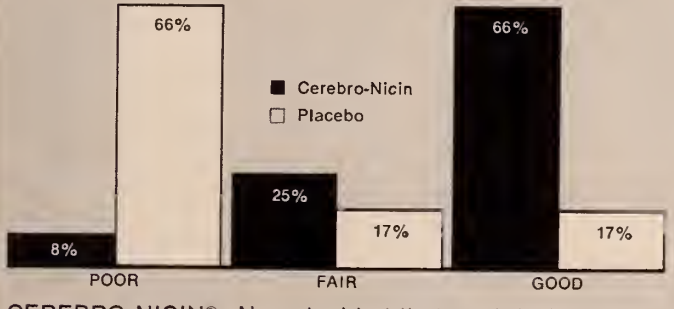
INDICATIONS. Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen – only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

when your patients need continuous potassium supplementation...



offer the unique choice of tangy lime, delicious orange

K-LYTE®

each effervescent tablet contains 2.5 Gm. potassium bicarbonate (25 mEq. elemental potassium), 2.1 Gm. citric acid, and cyclamic acid

sparkling, effervescent

With its two citrus flavors, K-Lyte offers really *special* taste appeal to assure long-term acceptance... patients will take the K-Lyte you prescribe.

Patients like the special convenience of K-Lyte. Each effervescent tablet dissolves quickly and completely in 3 to 4 ounces of cold water. Just two tablets daily provide 50 mEq. of elemental potassium to help prevent or correct potassium deficiency. K-Lyte is absorbed rapidly—and avoids any potential hazards of potassium chloride tablets.

to guide you in prescribing K-Lyte:

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color. **Contraindications:** When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted. **Precautions:** Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations. **Side Effects:** While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum. **Administration and Dosage:** K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement. **How Supplied:** Effervescent tablets—boxes of 30 (orange or lime).

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Mead Johnson
LABORATORIES

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

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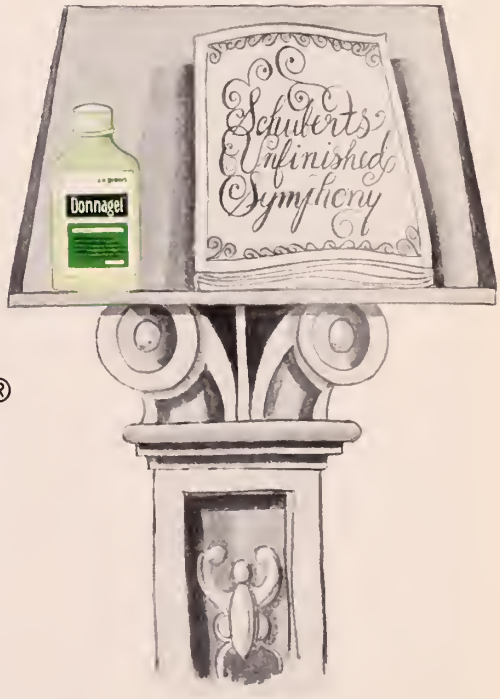
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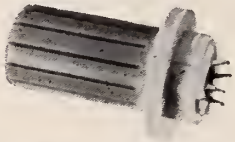
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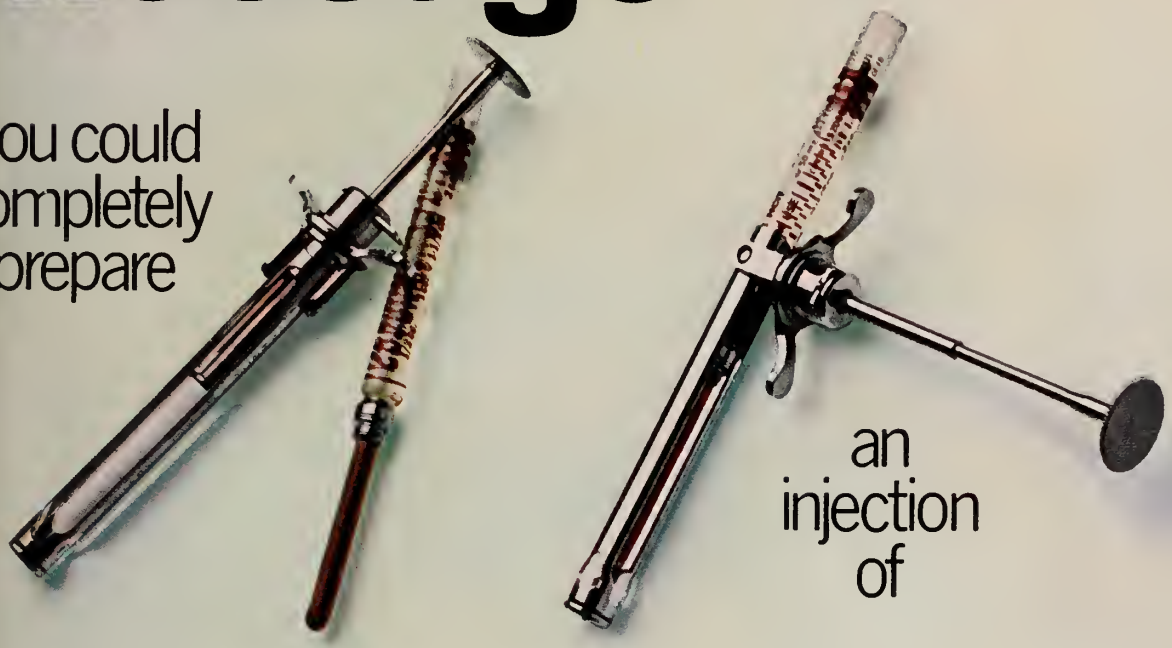
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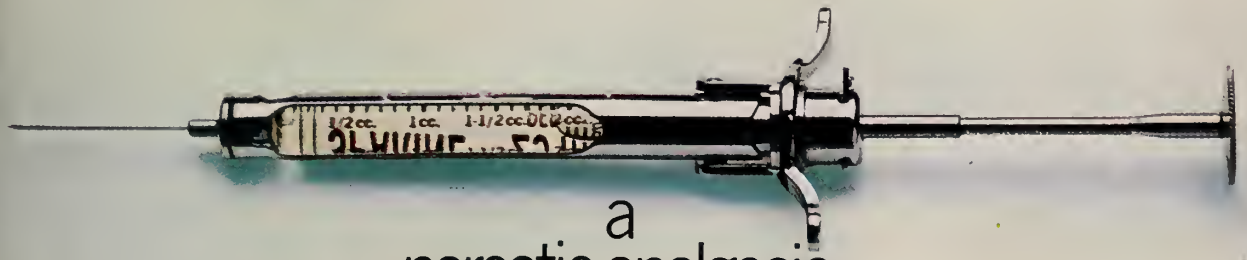
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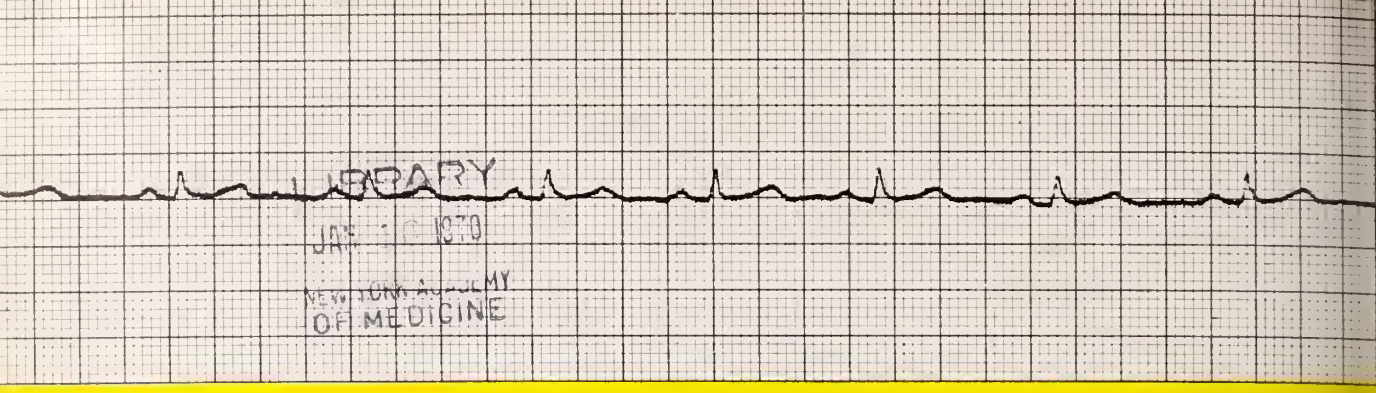
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